

1- FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR	
FRANK			Harold			IMLER			10 5 19 80			4:30 a	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR	
male	white	9/29/1950	30 YRS.			10 5 19 80						4:30 a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia			USA						Baltimore City			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore			South Baltimore General Hosp.			Trainman			Railroad				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
				Md.		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		829 Herndon Court	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Harold Eugene Imler, Sr.				Mabel Kleineick									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
Yes				Viet Nam				217-52-3800				Mabel Imler Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Multiple injuries													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				2:15xx 10-5-80				Operator of motorcycle/truck collision.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				street				100 E. Patapsco Ave. Balto. e. of Hanover St. Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Ann M. Dixon, M.D.				Assistant				10-5-80					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
				111 Penn St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				10/9/1980		Cedar Hill Cemetery				Ritchie Hwy. Balto. Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
McGully Funeral Home Balt. Md. 21225				OCT 7 1980				R. J. McBratney					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the medical attendant must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 2 1 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Bessie Isaac</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>October 18 / 80</i>			
3 SEX FEMALE				2b. HOUR <i>7:30 A.M.</i>			
4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR <i>JULY 1, 1910</i>		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6432 ELRAY DR., APT. D		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH JACOBS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER DIENER		13e. STREET ADDRESS 6432 ELRAY DR., APT. D #21209			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-07-9625		17 INFORMANT CLARENCE ISAACS 6432 ELRAY DR., APT. D #21209			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>none</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 years</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Rheumatoid Arthritis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 7</i> 19 <i>72</i> , to <i>Oct 18</i> 19 <i>80</i> , that (I) <i>last</i> saw the deceased alive on <i>Oct 18</i> 19 <i>80</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>was</i> (did not) view the body after death.							
22b. SIGNATURE <i>Manuel Levin M.D.</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>10/18/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN M.D.				22e. ADDRESS 6161 PK HORS AVE BALTO MD, 21215			
23a. BURIAL, CREMATION, REMOVAL (SPRINT) <i>Burial</i>		23b. DATE OCT. 19, 1980		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24 FUNERAL DIRECTOR NAME <i>Sam Levinson &amp; Sons Inc.</i>				24b. ADDRESS <i>6010 Reisterstown</i>		25a. DATE REC'D. BY REGISTRAR OCT 22 1980	
				25b. REGISTRAR'S SIGNATURE <i>Robert McElroy</i>			

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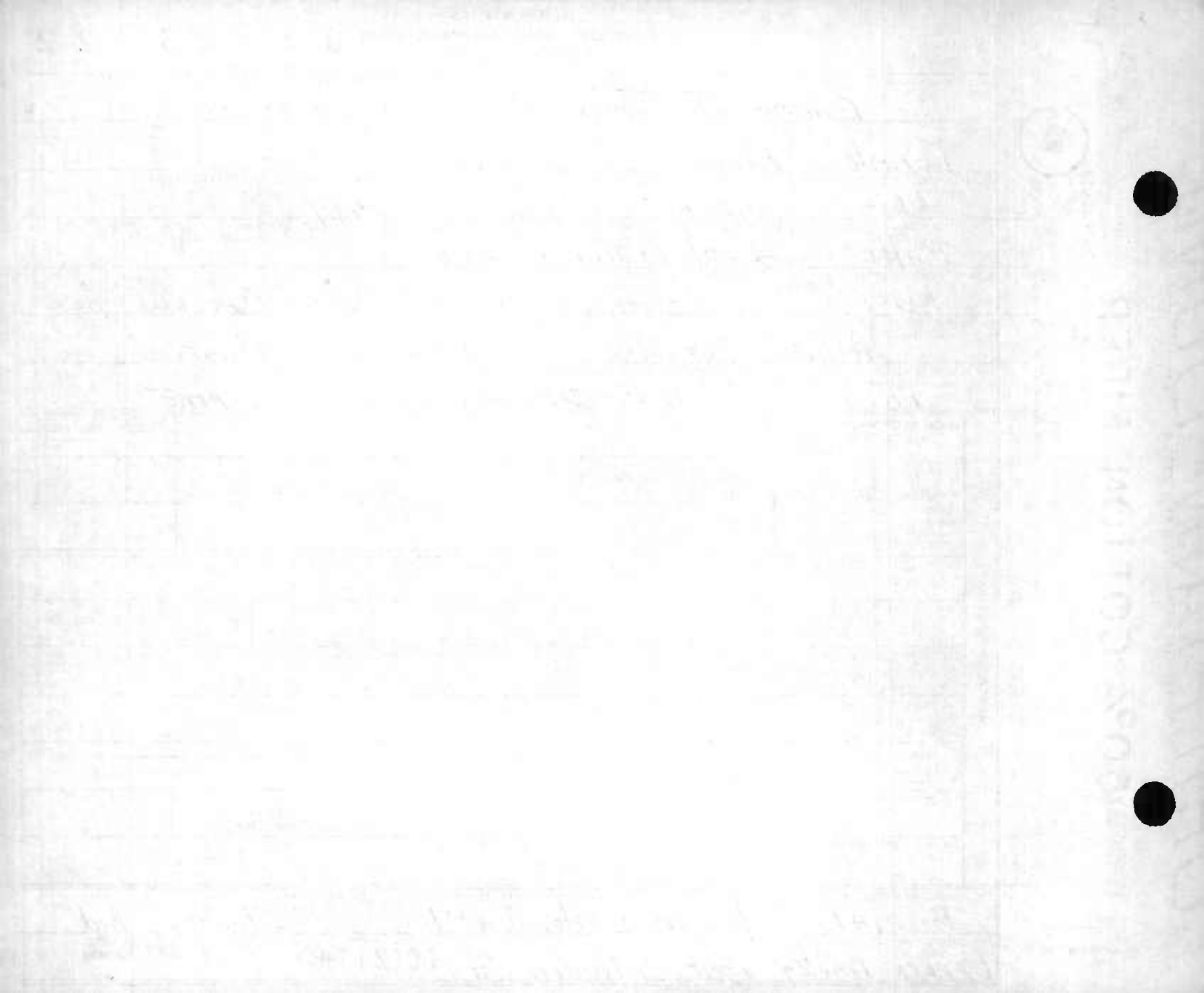
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 2 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) EMMA J. JACKSON			2a. DATE OF DEATH MONTH DAY YEAR 10-18-80		2b. HOUR M
3. SEX FEMALE	4. RACE NEGROID	5. DATE OF BIRTH MONTH DAY YEAR 10-25-07	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.		
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2221 CALLOW AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD.			13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST ALLIE WOODS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NAMIE CUSTUS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-15-7367	17. INFORMANT ADDRESS MARY WOODS SAME		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4370 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Disease - Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/20/80</u> 19 <u>80</u> to <u>Oct 18</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>5/20/80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MEDICAL EXAMINER		DEGREE		22c. DATE SIGNED 10/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.E. McCall MD		22e. ADDRESS 2600 Liberty Ave Ste 2025			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/23/80	23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT'L.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME VERNON BAILEY		ADDRESS 1348 CALHOUN ST.		25a. DATE REC'D. BY REGISTRAR OCT 21 1980	25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		8 0 2 5 5 2 3 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) ESTELLE - JACKSON					2a. DATE OF DEATH MONTH DAY YEAR 10 27 80			2b. HOUR 9:30 P.M.		
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 5 25 08		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-18-4616		17. INFORMANT Dorothy Barnes		ADDRESS 300 Grantley Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYELOCYTIC LEUKEMIA 2050 DUE TO, OR AS A CONSEQUENCE OF (b) PANCYTOPENIA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 WKS 1 YR.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia, @ lung										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (a) (this hospital) attended the deceased from 10/20, 1980, to 10/27, 1980, that (a) (we) lost saw the deceased alive on 10/27, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. PARBAMENT				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10/28/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. PARBAMENT				22e. ADDRESS 9518-B PHILA. RD. BALT. MD. 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/30/80		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland				
24. FUNERAL DIRECTOR NAME Wm. C. March Funeral Home Inc.				ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR OCT 29 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. Pages 5 and 6 should be filed within 72 hours after death. Pages 7 and 8 should be filed within 72 hours after death. Pages 9 and 10 should be filed within 72 hours after death. Pages 11 and 12 should be filed within 72 hours after death. Pages 13 and 14 should be filed within 72 hours after death. Pages 15 and 16 should be filed within 72 hours after death. Pages 17 and 18 should be filed within 72 hours after death. Pages 19 and 20 should be filed within 72 hours after death. Pages 21 and 22 should be filed within 72 hours after death. Pages 23 and 24 should be filed within 72 hours after death. Pages 25 and 26 should be filed within 72 hours after death. Pages 27 and 28 should be filed within 72 hours after death. Pages 29 and 30 should be filed within 72 hours after death. Pages 31 and 32 should be filed within 72 hours after death. Pages 33 and 34 should be filed within 72 hours after death. Pages 35 and 36 should be filed within 72 hours after death. Pages 37 and 38 should be filed within 72 hours after death. Pages 39 and 40 should be filed within 72 hours after death. Pages 41 and 42 should be filed within 72 hours after death. Pages 43 and 44 should be filed within 72 hours after death. Pages 45 and 46 should be filed within 72 hours after death. Pages 47 and 48 should be filed within 72 hours after death. Pages 49 and 50 should be filed within 72 hours after death. Pages 51 and 52 should be filed within 72 hours after death. Pages 53 and 54 should be filed within 72 hours after death. Pages 55 and 56 should be filed within 72 hours after death. Pages 57 and 58 should be filed within 72 hours after death. Pages 59 and 60 should be filed within 72 hours after death. Pages 61 and 62 should be filed within 72 hours after death. Pages 63 and 64 should be filed within 72 hours after death. Pages 65 and 66 should be filed within 72 hours after death. Pages 67 and 68 should be filed within 72 hours after death. Pages 69 and 70 should be filed within 72 hours after death. Pages 71 and 72 should be filed within 72 hours after death. Pages 73 and 74 should be filed within 72 hours after death. Pages 75 and 76 should be filed within 72 hours after death. Pages 77 and 78 should be filed within 72 hours after death. Pages 79 and 80 should be filed within 72 hours after death. Pages 81 and 82 should be filed within 72 hours after death. Pages 83 and 84 should be filed within 72 hours after death. Pages 85 and 86 should be filed within 72 hours after death. Pages 87 and 88 should be filed within 72 hours after death. Pages 89 and 90 should be filed within 72 hours after death. Pages 91 and 92 should be filed within 72 hours after death. Pages 93 and 94 should be filed within 72 hours after death. Pages 95 and 96 should be filed within 72 hours after death. Pages 97 and 98 should be filed within 72 hours after death. Pages 99 and 100 should be filed within 72 hours after death.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8025524  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL HOSEA JACKSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 23 80</b>			2b. HOUR <b>12:10 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 01 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greenbay, Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3905 Grantley Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Jackson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mollie Pate</b>			16. ADDRESS <b>N.W. Wash., D.C.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216-09-5479</b>		17. INFORMANT <b>Booker Jackson</b>		17b. ADDRESS <b>1762 Hobart St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>5850</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Chronic Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Renal Failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>yes -</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Congestive Heart Disease</b>										
19a. DATE OF OPERATION <b>23 Oct 80</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>23 Oct 80</b> to <b>23 Oct 80</b> , that (I) (we) saw the deceased alive above, (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Richard Tyson, MD.</b>			DEGREE <b>MD.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-23-80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD TYSON, MD.</b>			22e. ADDRESS <b>936 W. NORTH AV. BALTO MD. 21217</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/27/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>			ADDRESS <b>1101 E. North Ave.</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



R. H. Hines

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William

NO

Pr. Ho.

Jackon

Mollie

211-11-1111 Jackon

Pr. Ho.

Chas. Lewis Jones

Chas. Lewis Jones

Chas. Lewis Jones  
1111-11-1111

OCT 27 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8025525 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gladys James				October 21, 1980				10:23pm	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 7 2 25		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 217-86-9887		17. INFORMANT ADDRESS Charlene James 1522 N. Spring St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u> 5908 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia - aspiration</u> (c) <u>pyelonephritis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>19 Oct</u> , 19 <u>80</u> , to <u>21 Oct</u> , 19 <u>80</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>21 Oct</u> , 19 <u>80</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.									
22b. SIGNATURE <u>GBVogelsang MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STATE PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 21 Oct 80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GBVogelsang MD						22e. ADDRESS Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/27/80		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR OCT 24 1980		25b. REGISTRAR'S SIGNATURE	

RECEIVED OCT 27 1980

OCT 24 1980

*Handwritten signature*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 25526	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MARIE JAMES</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>OCT 5, 1980</b>		2b. HOUR <b>604 P</b>		M	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-22-02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CITY</b>					
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SBGH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>?</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2608 HOLLINS FERRY RD.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL SIMMS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADDIE WILLIAMS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>?</b>				16b. SOCIAL SECURITY NO. <b>217035128</b>		17. INFORMANT <b>CHARLES JAMES</b>		ADDRESS <b>2608 HOLLINS FERRY RD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCT, C</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIVENTRICULAR FAILURE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES, ASCVD,</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-05</b> 19 <b>80</b> , to <b>10-5</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>OCT 5</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>J. GILLINGHAM MD</b>						DEGREE		22c. DATE SIGNED <b>10-5-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. GILLINGHAM</b>						22e. ADDRESS <b>SBGH 3001 S. HARVARD ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10-9-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. (Westport) Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Chas. a. Rice FSPA</b>						1300 Eutaw Pl.		25a. DATE REC'D. BY REGISTRAR <b>OCT 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McBrady</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 2 7  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Gladys Jenkins</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>10 6 80</i>		2b. HOUR <i>125 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 2 29</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>51</i>		IF UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>		IF UNDER 24 HRS. HOURS MIN. <i>125 P.M.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i>		MD.			
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Lens Inspector</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>Optometry</i>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1426 Druid Hill Avenue</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Eli Cook</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Pate</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220 20 3446</i>		17. INFORMANT ADDRESS <i>Thomas Cook 3605 W. Mulberry St.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma, metastatic</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1991</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Superior vena cava syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (d) <i>pericardial effusion</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <i>9/29/80</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>pericardial effusion</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/12</i> 19 <i>80</i> , to <i>10/6</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10/6</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Gary B. Ruppert</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/6/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GARY B. RUPPERT</i>		22e. ADDRESS <i>301 ST. PAUL PL. 21202</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/10/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Balto Nat.</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Jas. A. Morton &amp; Sons 1701 Laurens St.</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>OCT 7 1980</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 2 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>NANCY JENKINS</b>				2a. DATE OF DEATH MONTH <b>10</b> DAY <b>14</b> YEAR <b>80</b>				2b. HOUR <b>3:45</b> A.M.	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>25</b> YEAR <b>87</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		# UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MASSON GA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NOT KNOWN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NOT KNOWN</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY OR TOWN <b>Baltimore</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>2117 Denison St</b>	
14. FATHER'S NAME FIRST <b>NOT KNOWN</b> MIDDLE <b>NOT KNOWN</b> LAST <b>NOT KNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>NOT KNOWN</b> MIDDLE <b>NOT KNOWN</b> LAST <b>NOT KNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218 098904A</b>		17. INFORMANT <b>MRS. MARIE FOX</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SENILITY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>NOT KNOWN</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>NOT KNOWN</b>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION <b>09/29/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>B-K Amp. (R) Leg</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>09/14</b> 19 <b>80</b> , to <b>10/14</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>09/14</b> 19 <b>80</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kwang N. Kim</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/14/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KWANG N. KIM MD</b>				22e. ADDRESS <b>730 ASHBURTON AVE</b>					
23a. BURIAL, CREMATION, REMOVAL (S) <b>BURIAL</b>		23b. DATE <b>10/20/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT AUBURN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MD</b>			
24. FUNERAL DIRECTOR <b>MD arrhan 8/11/80 655 1/2/80/1/80 1st</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 2 9

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		October 20, 1980		8:09P M	
Emma		B.		Jennings							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS	
Female		Black		MONTH DAY YEAR 2 23 20		60 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
S.C.		USA				Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Maryland General Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1236 Bonaparte Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Reuben Robinson		Sallie Walker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		250-32-0019		Lewis Jennings		1236 Bonaparte Street					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4439 Multiple Organ Failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Peripheral Vascular Disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
9/24/1980		Severe Aortic/Ilac Arterio-sclerotic Disease		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 28, 1980, to October 20, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 20, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Emmanuel J. Duvalaire		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		Oct. 29, 1980							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Emmanuel Duvalaire, M.D.		c/o Maryland General Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		10/27/80		Baltimore Cemetery		Baltimore					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. SIGNATURE							
Wm. C. March Funeral Home Inc		OCT 24 1980									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 5 5 3 0
1- FOR STATE REGISTRAR										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) <b>PETER S. N. JEW</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>10 25 80</b>		2b. HOUR <b>7:50 AM</b>		
3. SEX <b>Male</b>		4. RACE <b>Chinese</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>China</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5653 A Purdue Avenue</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unk.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unk.</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>568-40-3903</b>		17. INFORMANT <b>Widow:</b> ADDRESS <b>Florence G. Jew, 5653A Purdue Avenue</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE CEREBRAL VASCULAR DISEASE</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>10/21/80</b> , 19____, to <b>10/25/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/25/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Jerald Ward</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/25/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JERALD WARD</b>				22e. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/31/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Balto. Co., MD</b>				
24. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN COMPANY</b> NAME <b>Mowen F.H.</b> 108 W. <b>North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. [Signature]</b>				

MEDICAL CERTIFICATION



PETER S. H. JEN

BALTIMORE CITY

UNION MEMORIAL HOSPITAL

BALTIMORE

RECEIVED

107 N. A. Avenue

Baltimore

Baltimore

1911

1911

107 N. A. Avenue, Baltimore, Md.

To

10/17/10

NOV 3 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 3 1

FOR  
1- STATE  
REGISTRAR

REG NO.

1 DECEASED NAME (TYPE OR PRINT) William B Jewoda			2a DATE OF DEATH / MONTH DAY YEAR 10/30/80			2b HOUR 5:15 PM	
3 SEX MALE		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR JUNE 26 1922		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) UKRAN		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md		13b COUNTY Chesfield		13c CITY OR TOWN Old State Road		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William - Jewoda				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria - BONAR			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 167-32-2771		17 INFORMANT ADDRESS Hospital (Chart			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 1889 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Bladder ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intra-abd. sepsis, Aspiration pneumonia</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION 10/16/80		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumoperitoneum		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (I) (this hospital) attended the deceased from 19 80, to 10/30 19 80, that (I) (we) last saw the deceased alive on 10/30 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE JAI H JAH MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/30/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JAI H JAH MD				22e ADDRESS BCRP. UNIV. OF MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Nov. 3, 1980		23c NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Maryland	
24 FUNERAL DIRECTOR NAME McCully Funeral Home, 4200 Pennington Ave. Balto.				25a DATE REC'D. BY REGISTRAR NOV 5 1980		25b REGISTRAR'S SIGNATURE L. J. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 5 5 3 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Frederick W. Joeckel III				MONTH DAY YEAR 10 14 80			
3. SEX				2b. HOUR			
m				10 <sup>10</sup> P.M.			
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
W		MONTH DAY YEAR 6 17 35		45		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA		BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		ST AGNES HOSPITAL		Chief Gen. Acct.		Koppers Co.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Howard Ellicott City				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Frederick W. Joeckel Jr				FIRST MIDDLE LAST Grace Morgan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
No				216-32-0618		Ellicott City, Md. 21043 Doris Joeckel 3310 Coventry Court Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>BILATERAL MASSIVE BRONCHOPNEUMONIA</u>							
2000 DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>HISTIOCYTIC LYMPHOMA</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
				P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 19_____, that (we) last saw the deceased alive on 10/14 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
James E. Taylor				M.D.		10/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
JAMES E. TAYLOR				ST AGNES HOSPITAL 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10-17-80		Druid Ridge Cem		Pikesville Balto Md	
24. FUNERAL DIRECTOR 8728 Liberty Rd. Randallstown, Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Loring Byers Funeral Directors, P.A. 21133				OCT 21 1980			

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

DEC 1 1950

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

25533

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
LAWRENCE ALFRED JOHNSON			10 13 80			1:00pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	BLACK	5 10 15	65			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA	U.S.A.		BALTIMORE CITY, MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	VETERANS ADMINISTRATION MEDICAL CENTER		Retired					
13a. STATE			13b. COUNTY			13c. STREET ADDRESS		
MARYLAND			BALTIMORE			2809 PARKWOOD AVENUE 21215		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
WINDSOR THORNTON			LILLIE JONES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. HOME ADDRESS		
YES WWII			705077279			Mrs. Alice Johnson 2809 Parkwood Ave. VA Medical Records 3900 LOCH RAVEN BLVD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3949 IMMEDIATE CAUSE (a) <u>pulmonary embolus</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(b) <u>mitral valve endocarditis</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>metastatic cancer - 10 pancreas</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)								
<u>hepatic failure</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 17</u> , 19 <u>80</u> , to <u>OCTOBER 13</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>OCTOBER 13</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did <u>not</u> view the body after death.								
22b. SIGNATURE W. Myers MD				DEGREE		22c. DATE SIGNED		
				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10/14/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
W. MYERS				3900 LOCH RAVEN BLVD 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY		
Burial		10-18-80		Mt. Calvary Cem.		Balt. Co. - Gosh		
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph L. Russ 2222 W. North Ave.				OCT 20 1980		Ruthy M. Bandy		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 80 25534							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LOUISE P JOHNSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>10/22/80</b>			2b. HOUR <b>9:59 A.M.</b>	
3. SEX <b>F</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 22 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD</b>			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PROVIDENT</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS <b>2515 Druid Hill Ave</b>		
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY ANDREWS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Notie C. Motis</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>246-20-7755</b>		17. INFORMANT ADDRESS <b>KOOLIS W JOHNSON 2515 Druid Hill Ave</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC + RESP. ARREST</b> <b>5722</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>HEPATIC COMA - HEPATORENAL SYN.</b> (c) <b>HEPATIC COMA - HEPATORENAL SYN.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-8</b> , 19 <b>80</b> , to <b>10-22</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10-8</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Naomi Swift</b>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/22/80</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR CARLTON GREEN</b>					22e. ADDRESS <b>PROVIDENT HOSPITAL</b>				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>10/24/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fleming Rd</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Druid Hill Ave</b>		
24. FUNERAL DIRECTOR NAME <b>W P Hays</b>					25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Richard McCreedy</b>		

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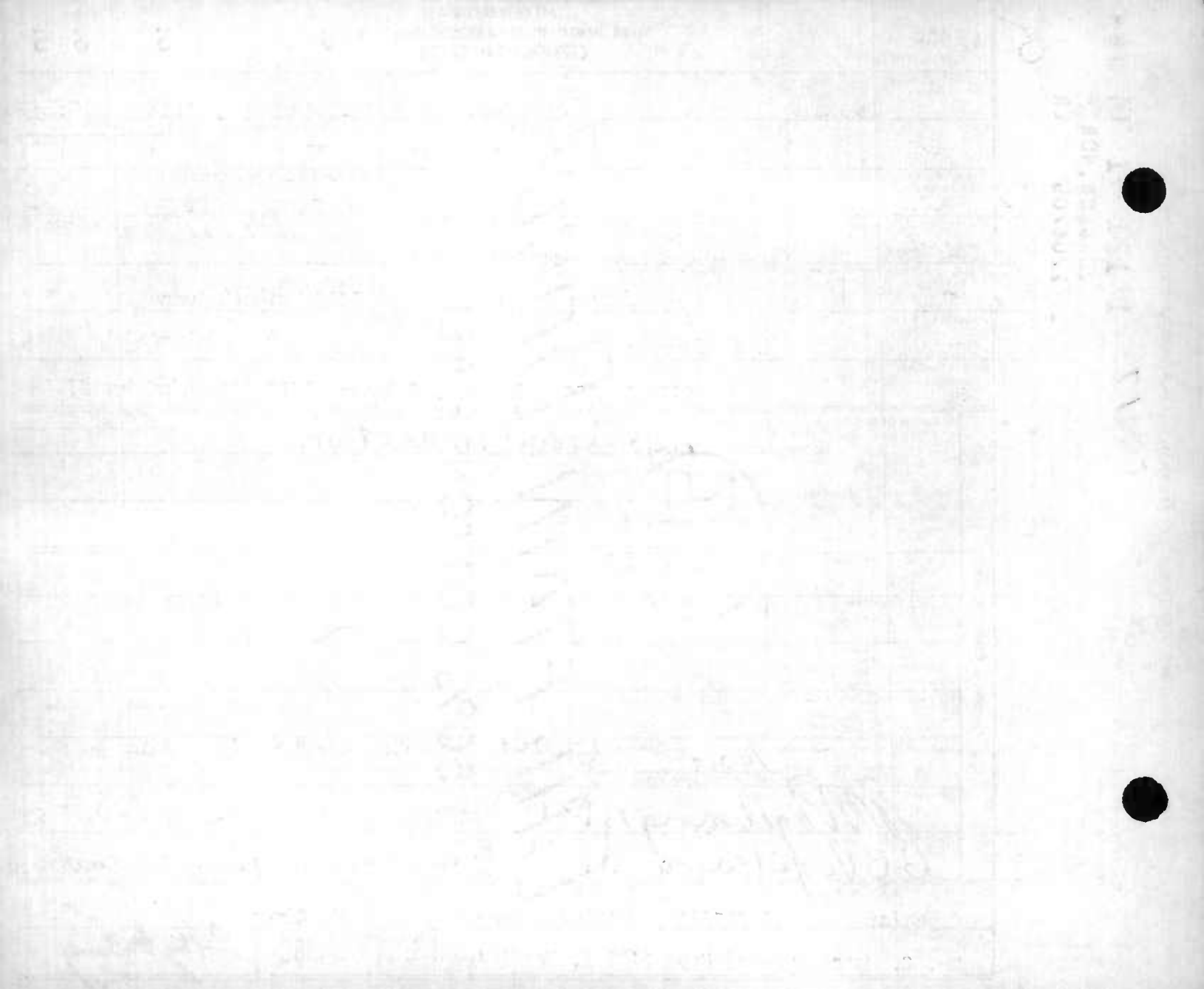
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 124 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 3 5 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORTH H JOHNSON								2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 14, 1980				2b. HOUR 06:50 PM	
3. SEX Male		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 2 6 05		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3619 Wasbash Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST James M. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Kirkpatrick									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213-01-6336		17. INFORMANT ADDRESS James M. Johnson 1012 Alexander Ave 21215							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <u>14 Oct</u> , 19 <u>80</u> , to <u>14 Oct</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>14 Oct</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>GB Vogelsang MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 14 OCT 80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GB Vogelsang MD				22e. ADDRESS Johns Hopkins Hospital Baltimore									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/17/80		23c. NAME OF CEMETERY OR CREMATORY Arbutus Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.							
24. FUNERAL DIRECTOR NAME Wm. C. March Funeral Home				ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR OCT 15 1980		25b. REGISTRAR'S SIGNATURE <u>Richard M. [Signature]</u>					

JHH  
124 hours of death  
JOHNSON, NORTH  
2/10/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 25536			
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM B. JOHNSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10/07/80</b>			
3. SEX <b>M</b>				4. RACE <b>B</b>			
5. DATE OF BIRTH MONTH DAY YEAR <b>2 26 02</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>				13b. COUNTY <b>Balto.</b>			
13c. CITY OR TOWN <b>Balto.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>2004 Cliftwood Ave.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219-05-8179</b>			
17. INFORMANT <b>Helen Johnson</b>				ADDRESS <b>2004 Cliftwood Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible large MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>410 -</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>under</b> <b>unclear</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9:07 19 80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9:07</b> , 19 <b>80</b> , to <b>9:40</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/3</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Wm Rector</b> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/5/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm Rector</b>				22e. ADDRESS <b>601 N Broadway</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/7/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Ricky K. Brady</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

FOR 1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 25537 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	PM
ANDREW				JONES, Jr.	10/22/80					2:18	M
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE	BLK	MONTH DAY YEAR 9 23 21		60		YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.							
N.C.	US										
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE	PROVIDENT										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2121 Windsor Garden Lane							
MD.		Balto.									
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME									
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST						
Andrew		Jones, Sr.	Hattie		Hymon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
Yes		WWII		216-14-8640		Louise Ward		2433 Edmondson Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4275</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22</u> , 19 <u>80</u> , to <u>10/27</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/22</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>N. Swygart</u>				DEGREE				22c. DATE SIGNED <u>10/23/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR BARAKAT</u>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		10/27/80		King Mem. Park		Baltimore Co., Md.					
24 FUNERAL DIRECTOR NAME <u>Wm C March F/H</u>				ADDRESS <u>1101 E. North Ave.</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 27 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. Page 4 should be filed within 72 hours after death. Page 5 should be filed within 72 hours after death. Page 6 should be filed within 72 hours after death. Page 7 should be filed within 72 hours after death. Page 8 should be filed within 72 hours after death. Page 9 should be filed within 72 hours after death. Page 10 should be filed within 72 hours after death. Page 11 should be filed within 72 hours after death. Page 12 should be filed within 72 hours after death. Page 13 should be filed within 72 hours after death. Page 14 should be filed within 72 hours after death. Page 15 should be filed within 72 hours after death. Page 16 should be filed within 72 hours after death. Page 17 should be filed within 72 hours after death. 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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. Page 4 should be filed within 72 hours after death. Page 5 should be filed within 72 hours after death. Page 6 should be filed within 72 hours after death. Page 7 should be filed within 72 hours after death. Page 8 should be filed within 72 hours after death. Page 9 should be filed within 72 hours after death. Page 10 should be filed within 72 hours after death. Page 11 should be filed within 72 hours after death. Page 12 should be filed within 72 hours after death. Page 13 should be filed within 72 hours after death. Page 14 should be filed within 72 hours after death. Page 15 should be filed within 72 hours after death. 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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8025538	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Baby Girl Jones						2a. DATE OF DEATH MONTH DAY YEAR October 20, 1980			2b. HOUR 4:50 a.m.		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH 10/ 20/ 80		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 24 HRS 53	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland						13b. COUNTY USA		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Cornell Jones						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret A. Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A				16b. SOCIAL SECURITY NO. N/A		17. MEDICAL RECORDS DEPARTMENT Maryland General Hospital 827 Linden Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 7798 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from October 20, 1980, to October 20, 1980, that X (we) lost saw the deceased alive on October 20, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Jo Ann Santos, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/20/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jo Ann Santos, M.D.						22e. ADDRESS c/o Maryland General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/23/80		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board						25. DATE REC'D. BY REGISTRAR OCT 27 1980		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 3 9  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		10-11-80		430 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		BLACK		12 25 01		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
VA		USA				Baltimore City MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		University Hospital		Domestic			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		755 W. Lexington St			
BERNARD E. Jones		UK UK BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
UK		UK		BERNARD Jones		755 W. Lexington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIFFUSE HISTOCYTIC LYMPHOMA</u> <u>2000</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-4</u> , 19 <u>80</u> , to <u>10/10</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/11</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sidney M. Crain MD</u>				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
SIDNEY M. CRAIN MD				BCRP 225 Greene St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10-13-80		MT. AUBURN Cem.		BALTO. MD.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Chas. H. Powell/H/H 319 N. Schroeder St.				OCT 14 1980		L. J. Schaefer	

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MADE IN U.S.A.

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	2	5	5	4	0	
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN BENJAMIN JONES</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>10 29 80</b>				2b. HOUR <b>3:44p M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 1 15</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LOWA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>										
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VETERANS ADMINISTRATION MEDICAL CENTER</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Navy</b>					
13a. STATE <b>MARYLAND</b>										13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Middle River</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1219 SHORE ROAD 21220</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Asa - Jones</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leanna - Swisher</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT <b>Alma C. Jones, wife</b>		ADDRESS <b>Same</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> <b>0119</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE PULMONARY INFECTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>NO POSSIBLY TUBERCULOSIS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)																	
19a. DATE OF OPERATION <b>10-23-80</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NON-VIABLE (R) LEG</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 21 19 80</b> to <b>OCTOBER 29 19 80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>OCTOBER 29 19 80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.																	
22b. SIGNATURE <b>Bert R Mandelbaum M.D.</b>								DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-29-80</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERT R MANDELBAUM</b>								22e. ADDRESS <b>JOHNS HOPKINS HOSP. DEPT OF SURGERY</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-1-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harford County, Maryland</b>							
24. FUNERAL DIRECTOR <b>Bruzdinski Funeral Home PA 1407 Old Eastern Ave.</b>								25a. DATE REC'D. BY REGISTRAR <b>OCT 31 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Rita J. McCreedy</b>							

[illegible]

17. J. Jones, 1917

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 4 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Junious W.. Jones		2a DATE OF DEATH MONTH DAY YEAR October 8, 1980		2b HOUR M	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Jan 9, 1901	
6 AGE (IN YEARS LAST BIRTHDAY) 79		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City		10 CITY OR TOWN OF DEATH Baltimore	
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1204 Myrtle Ave.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofers		12b KIND OF BUSINESS OR INDUSTRY Roofing Co.	
13a STATE Maryland		13b COUNTY		13c CITY OR TOWN Baltimore	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1204 Myrtle Avenue		14 FATHER'S NAME FIRST MIDDLE LAST Wyatt Jones	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 216-07-2496-A	
17 INFORMANT ADDRESS Mrs. Lille Belle Jones-1204 Myrtle Ave. 21217		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Possible Silent Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Old Cerebrovascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 5-24, 1980, to Oct. 8, 1980, that (I) (we) last saw the deceased alive on August 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Donato A. Vargas	
22c. DATE SIGNED 10-9-80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONATO A. VARGAS, JR		22e. ADDRESS 6010 York Rd Baltimore, Md 21212	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 11, 1980		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Maryland		24. FUNERAL DIRECTOR NAME Herbert E. Nutter-3035 W. North Ave.		25a. DATE REC'D. BY REGISTRAR OCT 14 1980	
25b. REGISTRAR'S SIGNATURE R. E. Nutter		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	



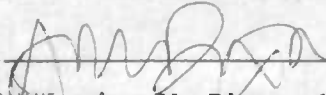
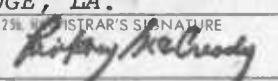
REPORT OF THE BOARD OF DIRECTORS

OCT 1 1960

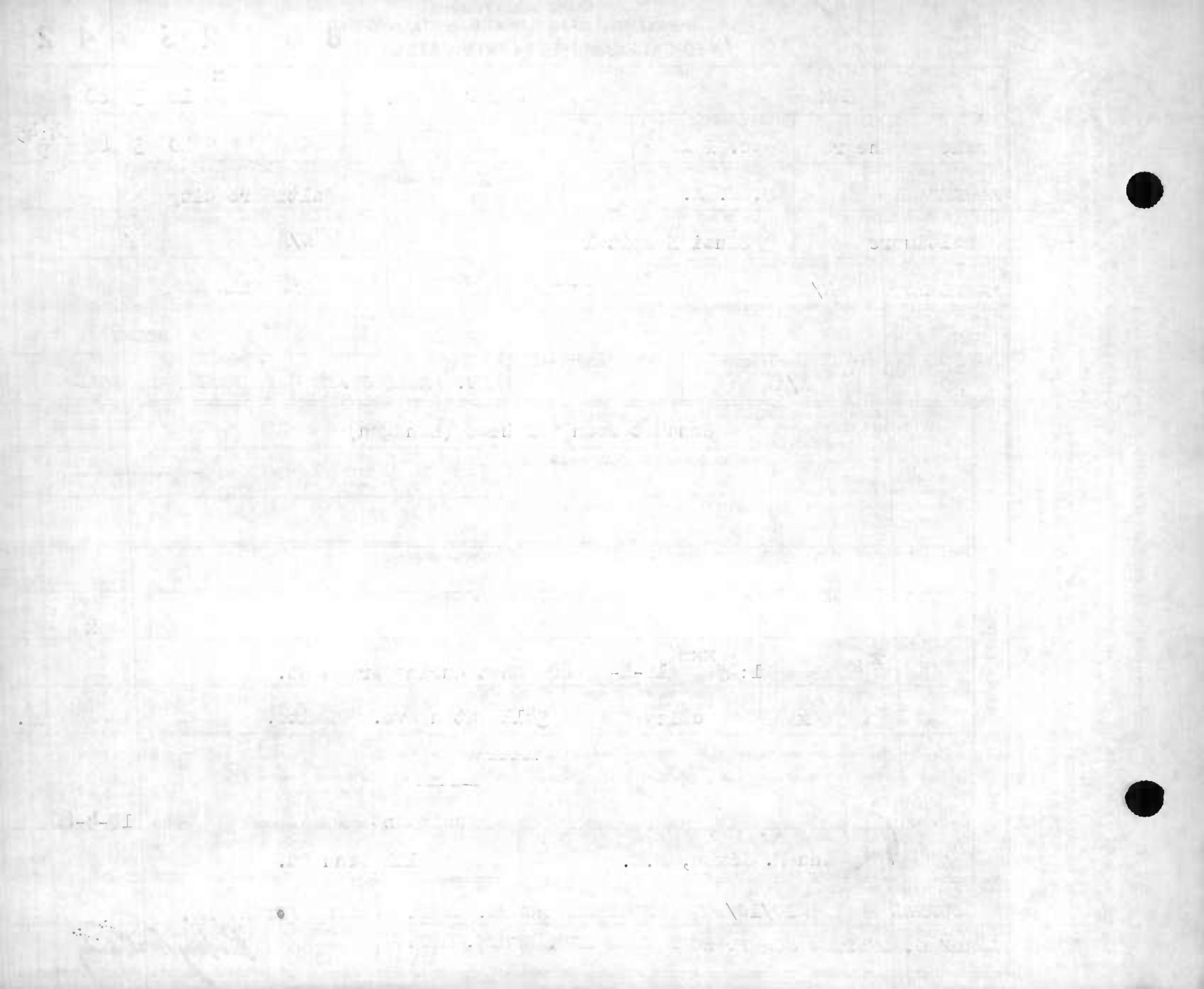
STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 1- FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>SAM</b>		FIRST		MIDDLE		LAST <b>JONES JR.</b>		20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>10 3 1980</b>		26. HOUR <b>M</b>	
3. SEX <b>male</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 21, 1949</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>31</b> YRS.		IF UNDER 1 YR. MONTHS DAYS <b>10 2 1980</b>		IF UNDER 24 HRS. HOURS MIN <b>10 3 1980</b>		24. HOUR <b>4:45</b> <b>P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LOUISIANA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>N/A</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4622 PALL MALL ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAM JONES</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MABLE BROWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>MRS. MABLE JONES 4622 PALL MALL ROAD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head (handgun)</b> 9650 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>1:15 P.M. 10-2-1980</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Shot during argument.</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>alley</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3411 Paton Ave. Balto. Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Assistant</b>						DATE SIGNED <b>10-4-80</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10/10/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SOUTHERN HGHTS. CEME.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BATON ROUGE, LA.</b>					
24. FUNERAL DIRECTOR <b>LEROY O. DYETT &amp; SON F. ADD</b>				HOME <b>4600 LIB. HGHTS. AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 8 1980</b>		25b. REGISTRAR'S SIGNATURE 			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

Shirella Conita

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

B-G RACHEL

JONES

2b. DATE OF DEATH MONTH DAY YEAR

10/2/80 10 2 80

2b. HOUR

8:10 a.m.

3. SEX

Female

4. RACE

Negro

5. DATE OF BIRTH

MONTH

DAY

YEAR

9 29 80

6. AGE (IN YEARS LAST BIRTHDAY)

0

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Baltimore City Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

---

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Calvert

13c. CITY OR TOWN

Huntingtown

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

Box 302-B

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Galvin

Jones

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Rachel

Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

-----

17. INFORMANT

ADDRESS

Rachel Jones Box 302-B, Huntingtown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ACUTE RENAL FAILURE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

7689  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

SEVERE ASPHYXIA NEONATORUM

3 days

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/29 / 19 80 to 10/2 / 19 80 that (I) (we) last saw the deceased alive on 10/2 / 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

bied-jyu Wong

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

10/2/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SIEW-JYU WONG

22e. ADDRESS

BCH.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Oct. 06-80

23c. NAME OF CEMETERY OR CREMATORY

St. Edmonds Chr. Cem.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Chesapeake Beach, Cal., Md.

24. FUNERAL DIRECTOR

NAME

Spencer E. Sewell Box 31, PRINCE FREDERICK, MD.

25a. DATE RECEIVED BY

OCT 7 1980

25b. REGISTRAR'S SIGNATURE

[Signature]

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

7-11

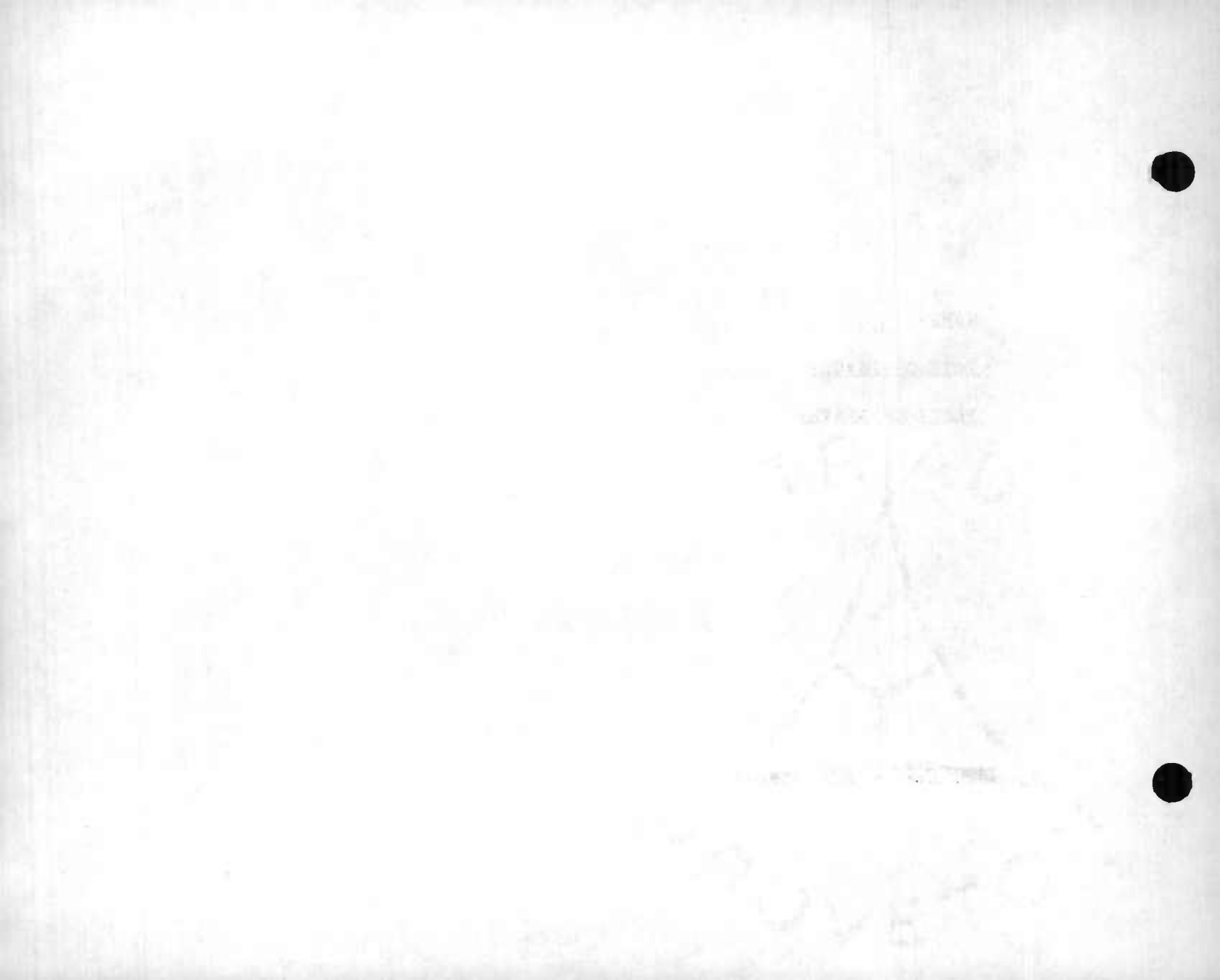
**NAME:** Louis Andrew Jordan, Sr.

**DATE OF DEATH:** October 5, 1980

**PLACE OF DEATH:** Baltimore City

**SEE:** Cert. #80-24882  
Baltimore County

DEMH 2485 - Vit. Rec.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 4 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Helen S. Kaiser			2a. DATE OF DEATH MONTH DAY YEAR Oct. 4, 1980			2b. HOUR 3-18 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 1, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1456 Patapsco St. Balto. Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1456 Patapsco St. Balto. Md.		
14. FATHER'S NAME FIRST MIDDLE LAST Andrew ----- Anderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ----- Vickers			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-26-9441	
17. INFORMANT ADDRESS Mr. Paul Kaiser, Sr. Same as above											

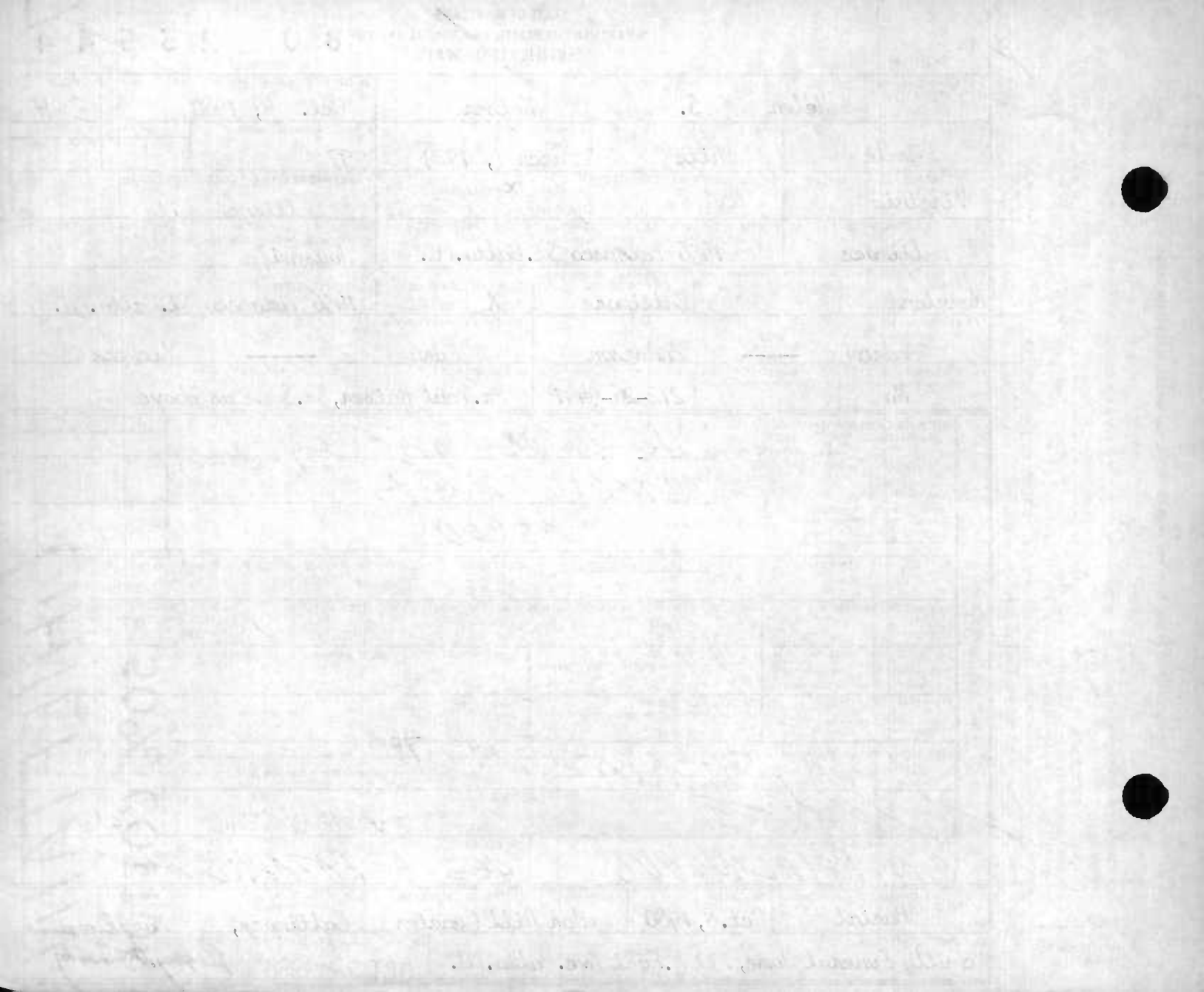
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Malignancy</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prostatic Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 29</u> , 19 <u>79</u> , to <u>Sept 29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Sept 29, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P.N. PATALINGHUS				22e. ADDRESS 403 - E PATAPSCO AVE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 8, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS McQuilly Funeral Home, 130 E. Fort Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR OCT 7 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 5 5 4 5	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
SARAH Roberta KALATA				October 27, 1980	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female	White	March 19, 1922		58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Penna.	U.S.A.			Baltimore City, MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	3707 Overlea Ave.		Housewife		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3707 Overlea Ave
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
? Walker		Sarah ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
No		182-12-1939		Mr Joseph P Kalata Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-29-79</u> , 19 <u>79</u> , to <u>10-11</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>10-10-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		M.D.		10-27-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Sebastian Russo, M.D.		5122 Harford Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
Cremation		11/7/80	Greenmount	Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc.		Baltimore, Md.		NOV 6 1980	

MEDICAL CERTIFICATION

100-100000-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				80 25546			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Henry C HANE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 7 80</b>			
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 05 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>City</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Hane</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Luphia Opher</b>		13e. STREET ADDRESS <b>4609 Old Frederick Rd</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK</b>		16b. SOCIAL SECURITY NO. <b>217108530</b>		17. INFORMANT ADDRESS <b>Chart</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4232</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Constrictive Pericarditis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Constrictive Pericarditis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>24 rs</b> <b>24 rs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Mesothelioma 1975</b>							
19a. DATE OF OPERATION <b>10/5/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Constrictive Pericarditis</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> , 19 <b>80</b> , to <b>10/7</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/7</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Nelson N Stone MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nelson N Stone MD</b>				22e. ADDRESS <b>225 Greene St Baltimore</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-11-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Madison Church Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Madison Md</b>	
24. FUNERAL DIRECTOR NAME - <b>Thompson F. H.</b> <b>Isaiah L. Brown &amp; Son PA 1913 W. Balto. St</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1980</b>		25b. SIGNATURE <b>Isaiah L. Brown</b>	

0 1 0 2 1 8



RECEIVED  
OCT 14 1960



OCT 14 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 4 7

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>BABY BOY KANG</b>			2a DATE OF DEATH MONTH <b>10</b> DAY <b>29</b> YEAR <b>80</b>			2b HOUR <b>850P.M.</b>			
3 SEX <b>M</b>		4 RACE <b>O</b>		5 DATE OF BIRTH MONTH <b>10</b> DAY <b>29</b> YEAR <b>80</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. <b>1</b>		7 UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>	
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		8b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTCITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALT</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>U MD HOSP</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD</b> 13b COUNTY <b>BALTO. CITY</b> 13c CITY OR TOWN <b>BALTO.</b>					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>208 E. PRESTON ST.</b>		

14 FATHER'S NAME FIRST <b>Jim</b> MIDDLE <b>W</b> LAST <b>KANG</b>		15 MOTHER'S MAIDEN NAME FIRST <b>Fun - Hee</b> MIDDLE <b>HEE</b> LAST <b>HEE</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO <b>NONE</b>	
17 INFORMANT <b>JIM W. KANG</b>		ADDRESS <b>208 E. Preston St.</b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cyanotic Congenital Heart Disease</b> <b>7469</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION <b>10/29/80</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>19</b>		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			

22a I certify that (I) (this hospital) attended the deceased from **10/29**, 19 **80**, to **10/29**, 19 **80**, that (I) (we) last saw the deceased alive on **10/29**, 19 **80**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE <b>Susan U. Previas md</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>10/29/80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUSAN PREVIAS</b>				22e ADDRESS <b>UNIVERSITY OF MARYLAND HOSPITAL</b>			

23a <del>23a</del> CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b DATE <b>11-1-80</b>		23c NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b>		23d LOCATION CITY OR TOWN <b>Catonsville, Md.</b> COUNTY <b>MD.</b> STATE	
24 FUNERAL DIRECTOR NAME <b>Sanders Funeral Home</b> ADDRESS <b>217 E. Preston St.</b>				25a DATE REC'D. BY REGISTRAR <b>NOV 3 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1 2 3 4 5 6



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

720 3 2 9 1

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 2 5 5 4 8			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Gentie Kaplan				10 24 80 3:30 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		10-12-1894		86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Poland		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Sinai Hospital		Housewife			
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS	
N.J.				Union		1010 Voorhees St.	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Unk				Unk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Unk		Mildred Brans 977 Clapper Rd. Gaitersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) acute MI							
4100							
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/28, 1980, to 10/28, 1980, that (we) lost saw the deceased alive on 10/28, 1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Leon G. Sheer						10/29/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Leon G. Sheer, M.D.				6715 Park Heights Ave., Balto. 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10-30-80		Bnai Abraham Cem.		Union Union N.J.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D BY REGISTRAR		25b. SIGNATURE	
Hardesty Funeral Home				12 Ridges Ave. Md.		NOV 6 1980	



Gentle

Kao-an

Female

10-12-1904

86

Baltimore City

St. John's Hospital

St. John's Hospital

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St. John's Hospital

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St. John's Hospital

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St. John's Hospital

St. John's Hospital

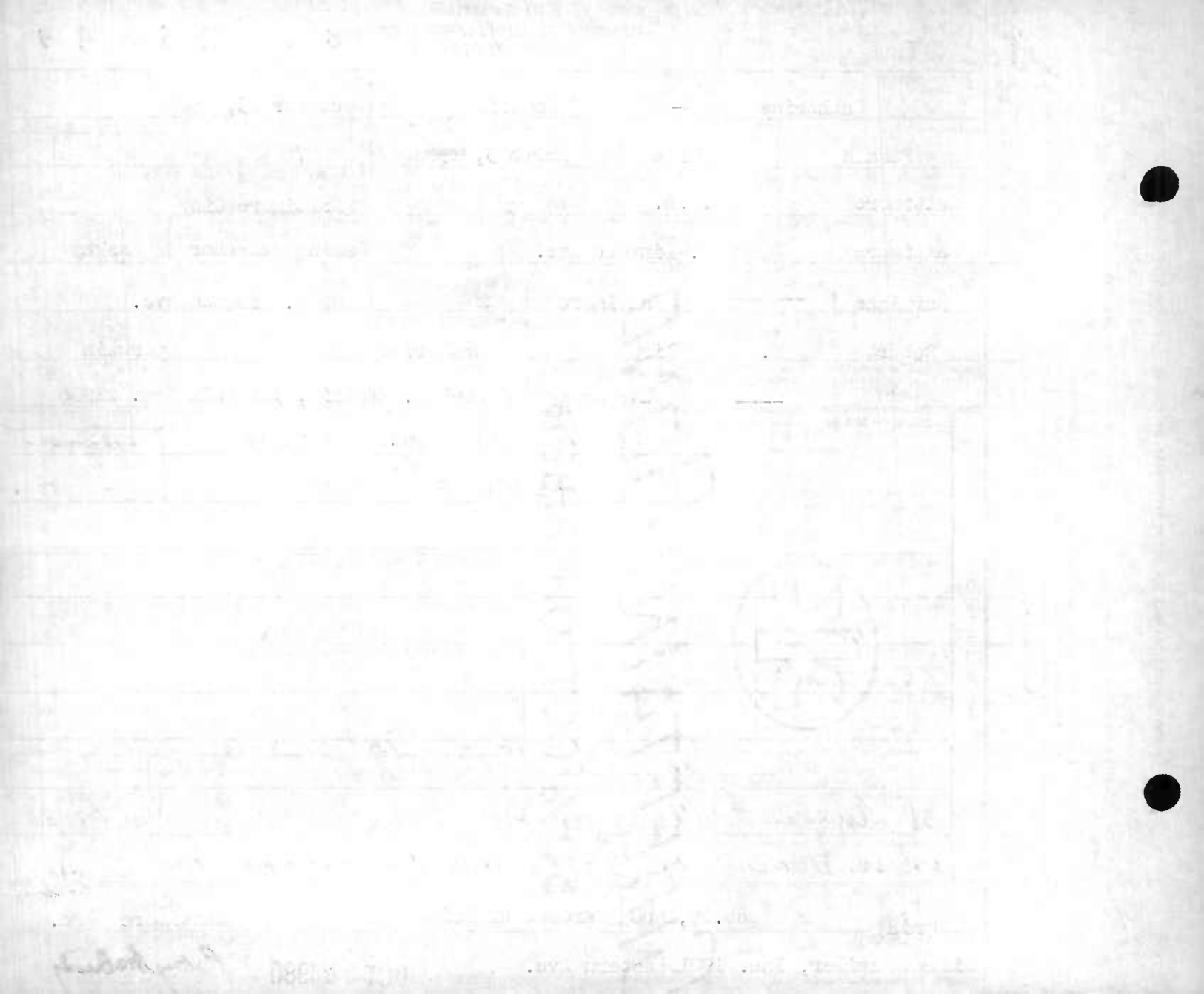
St. John's Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. FOR STATE REGISTRAR		Item 18 G549 11/21/80		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7 0 2 5 5 4 9	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Catherine		—		Kaptain			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		1904 March 5, 1980		76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		U.S.A.				Baltimore City MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		102 N. Linwood Ave.		Casing Selector		Esskay	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Robert		Catherine		No		220-12 = 5048	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u>		19. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
Joseph M. Kaptain, 516 Dale Ave. 21206		4100		21a. TIME OF INJURY		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD &amp; Emphysema</u>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		DUE TO, OR AS A CONSEQUENCE OF (c)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		21d. INJURY OCCURRED		21e. LOCATION	
				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE	
				22a. I certify that (I) (this hospital) attended the deceased from <u>6-16</u> , 19 <u>75</u> , to <u>8-10</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>7-29</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Natural</u>		22b. SIGNATURE	
				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
				10-27-80		DR. W. DUNCAN McCLEARY	
				22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
				448 N. LUZERNE AVE BALTO, MD		Burial	
				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
				Oct. 29, 1980		Gardens of Faith	
				23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR	
				Baltimore Md.		OCT 28 1980	
				23f. REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR NAME ADDRESS	
				Lilly & Zeiler, Inc. 1901 Eastern Ave.		24. DATE REC'D. BY REGISTRAR	
						OCT 28 1980	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

25550

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAX KARPA			2a. DATE OF DEATH MONTH DAY YEAR 10-9-80			2b. HOUR 9:37 AM			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH APR. 15, 1903 <sup>R</sup>		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JACOB KARPA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MIRIAM RESHOTLSO			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 217-22-8304			17. INFORMANT MR. MORTON KARPA 215 INDIAN SPRINGS DR., SILVER SPRING, MD 20901						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Small Bowel Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCUD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> 19 <u>80</u> , to <u>10/9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE P Rivas MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P Rivas			22e. ADDRESS Mercy Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE OCT. 10, 1980		23c. NAME OF CEMETERY OR CREMATORY OHR KNESSETH ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE ANSHE SFARD ROSEDALE MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE R. J. McCreedy	

MEDICAL CERTIFICATION

0222 164

RECEIVED  
OCT 11 1960

10-11-60

10-11-60

OCT 11 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 5 1			
FOR 1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) James P. Kelly				2a. DATE OF DEATH MONTH DAY YEAR October 17, 1980			
3. SEX MALE				2b. HOUR 4:40 P.M.			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 24, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST PATRICK J. KELLY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES DYER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-14-2505		17. INFORMANT ADDRESS RUTH M. KELLY 5623 READY AVE. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Of Lung With Probable Metastasis</u> <u>To The Brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 14</u> , 19 <u>80</u> , to <u>October 17</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>October 17</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <u>Harry E. Nervino, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-18-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Nervino, M.D.				22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 21, 1980		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212				25a. DATE REC'D. BY REGISTRAR OCT 22 1980		25b. REGISTRAR'S SIGNATURE <u>Harry E. Nervino</u>	

1 2 3 4 5 6 7 8 9 10 11 12

James M. Kelly

WHITE

2625 Madison Ave. Baltimore City

Baltimore General Hospital

2625 Madison Ave. Baltimore City

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 5 5 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph L. Kelly				2a. DATE OF DEATH MONTH DAY YEAR October 28, 1980			
3. SEX Male				4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-30-04	
6. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2b. HOUR About 4 <sup>am</sup>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4260 Nicholas Ave				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Painter	
12b. KIND OF BUSINESS OR INDUSTRY Auto Shop		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kelly				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Selia Quite			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216100036		17. INFORMANT ADDRESS Evelyn E. Kelly 4260 Nicholas Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-3 hrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Malnutrition secondary to bowel surgery; history of ulcer disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM PM DAY MONTH YEAR 11 AM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from August 7, 1979, to October 8, 1980, that (I) (we) lost saw the deceased alive on September 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jerald Ward				DEGREE M.D.		22c. DATE SIGNED 28-OCT-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERALD WARD				22e. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-30-80		23c. NAME OF CEMETERY OR CREMATORY Baltimore County		23d. LOCATION (CITY OR TOWN) COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Grace H. Ulrich Parkside Funeral Home Inc.				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 30 1980			

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2642 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 25553			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 10 26 80			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEVI KELLY				2b. HOUR 9:45 AM			
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 14 97		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 83 Whitestone, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH 90 Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 35 Greater Penna Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 130 Maryland				13b. COUNTY BALTO.			
14. FATHER'S NAME FIRST MIDDLE LAST OTIS KELLY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA WOODS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-05-8635		17. INFORMANT ADDRESS Mr. Vernon Kelly 3002 Elgin Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4292 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): Bilateral AK Amputee							
19a. DATE OF OPERATION 9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 9-11 19 78 to 10-27-19 80, that (we) lost saw the deceased alive on 10-26 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.							
23a. SIGNATURE Richard Tyson, MD.				DEGREE		23c. DATE SIGNED 10-27-80	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD Tyson, MD.				23d. ADDRESS 936 W. NORTH AVE. BALTO. 21211 MD.			
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23f. DATE 10-29-80		23g. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23h. LOCATION CITY OR TOWN COUNTY STATE BALTO. Co. Md.	
24. FUNERAL DIRECTOR NAME Joseph L. Russ				ADDRESS 2553 W. North Ave.		25a. DATE REC'D. BY REGISTRAR OCT 28 1980	
				25b. REGISTRAR'S SIGNATURE R. Tyson			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 5 4

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN CATHERINE KELLY			10/24/80			8:00 M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 31 04	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 75			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Manor Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown			12b. KIND OF BUSINESS OR INDUSTRY Unknown	
13a. STATE Md.			13b. COUNTY -----			13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST Paul Milwicz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST -Unknown- JOSEPHINE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214 44 0215			16c. INFORMANT ADDRESS Pleasant Manor Nursing Center 4615 Park Heights Ave., 21215		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Apoplexy</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>3 months</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Meningioma of Brain</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>80</u> , to <u>10-24</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10-24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Jaime Punzalan</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/24/1980
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jaime Punzalan, M. D.			22e. ADDRESS 5214 Harford Rd., 21206					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/27/1980		23c. NAME OF CEMETERY OR CREMATORY MT. CARMEL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME DIPPEL FUNERAL HOMES 7110 BELAIR RD. BALTO MD.			ADDRESS 21206		25a. DATE REC'D. BY REGISTRAR OCT 27 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 2 5 5 5 5		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
FIRST MIDDLE LAST <b>Ronald Francis Kelly</b>				MONTH DAY YEAR <b>October 7, 1980</b>				<b>10:39AM</b>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
<b>Male</b>		<b>Caucasian</b>		MONTH DAY YEAR <b>Sept. 2, 1940</b>		<b>40</b> YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
<b>Maryland</b>		<b>U.S.A.</b>				<b>Baltimore City</b> MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>Baltimore</b>		<b>U.S.P.H. Service Hospital</b>				<b>Service man</b>		<b>Government</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
STATE COUNTY CITY OR TOWN <b>Maryland Baltimore Baltimore</b>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>8547 Harris Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles J. Kelly</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Dove</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (GIVE LAST FOUR DIGITS)		17. INFORMANT ADDRESS					
<b>Yes</b>		<b>1965-1968</b>		<b>U.S. Public Health Service medical records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure, terminal</b> <b>5724</b> DUE TO, OR AS A CONSEQUENCE OF <b>Hepatorenal syndrome</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 22, 1980</b> , to <b>OCT 7, 1980</b> , that (I) (we) last saw the deceased alive on <b>10/7/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Duncan Salmon MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/8/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DUNCAN SALMON MD</b>				22e. ADDRESS <b>3100 WYMAN PARK DR BALT MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-10-1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CROWNSVILLE VET.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS FUNERAL CHAPL 8800 HARTFORD RD.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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Richard Smith

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 5 5 5 6

1. DECEASED NAME (TYPE OR PRINT) <b>STELLA ANNA KEMPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-24-80</b>		2b. HOUR <b>9:28 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CACASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-12-93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CITY HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK.</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>EASTWOOD</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ERNEST SCHRIVER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SUSAN SPANGLER</b>		13e. STREET ADDRESS <b>7301 BRIDGEWOOD DRIVE #21224.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-74-3017</b>		17. INFORMANT <b>HELEN GALICKI ;</b>		ADDRESS <b>7301 BRIDGEWOOD DRIVE. EASTWOOD, 21224, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>0389</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SEPTIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> , 19 <b>80</b> , to <b>10/24</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/24</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. JAIN</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/24/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. JAIN</b>				22e. ADDRESS <b>B. C. H.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>OCT. 28, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>7225 EASTERN BLVD. BALTO., CO., MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Charles S. Zeller &amp; Son, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1980</b>		25b. REGISTRAR'S SIGNATURE <b>John M. Kelly</b> MD.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 5 5 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Murtle</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/29/80</b>			2b. HOUR <b>6:40 P.M.</b>			
3. SEX <b>female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 - 5 - 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>yes USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto., MD.</b>			
10. CITY OR TOWN OF DEATH <b>Balto., Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RESIDENCE 2105 PENNA. AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Librarian</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward J. Bosley</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Mae Campbell</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Charles Tilghman</b>			ADDRESS <b>2105 Penna. Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypercalcemia + Malignant Anemia</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ovarian Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sept 79</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/26/80</b> , 19 <b>80</b> , to <b>10/29</b> , 19 <b>80</b> , that (I) (we) saw the deceased alive on <b>9/5/80</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>William C Waterfield</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/31/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William C Waterfield</b>			22e. ADDRESS <b>ST AGNES HOSP 900 CATON AVE BALT MD 21043</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/1/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Leroy O. Dyett</b>			ADDRESS <b>4600 Liberty Heights</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Ruby Rebury</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 5 5 5 8									
1. FOR STATE REGISTRAR		REG. NO.																	
2a. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH		MONTH		DAY		YEAR		2c. HOUR			
MINNIE		KESSLER.						10-19-80		1:20 P.M.									
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS		MONTHS		DAYS		HOURS			
FEMALE		WHITE		JULY 4, 1896		84 YRS.													
2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH													
MARYLAND		USA				BALTIMORE CITY MD.													
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		SINAI HOSPITAL						HOUSEWIFE				AT HOME							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
										MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3800 GLENGYLE AVE. #21215	
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST				FIRST MIDDLE LAST															
ISAAC				KAPLAN				LEAH HURST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17 INFORMANT											
NO				219-32-6751				MR. JACOB KAPLAN				3703 SEVEN MILE LA., APT. B 2 #21208							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>																			
436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRO VASCULAR ACCIDENT.</u>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION											
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>8/10/80</u> to <u>10/19/80</u> , that (I) (we) last saw the deceased alive on <u>10/19/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED							
<u>Benjamin M.</u>												10/19/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS															
NELSON BENTERS				SINAI HOSPITAL															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
BURIAL				OCT. 20, 1980				FRIEDEL MARYLAND LODGE				CITY OR TOWN COUNTY STATE							
								ROSEDALE				BALTO. MD							
24 FUNERAL DIRECTOR NAME				24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
SOL LEVINSON & BROS., INC.								OCT 22 1980				<u>Robert M. Brady</u>							
6010 REISTERSTOWN RD. BALTO., MD 21215																			



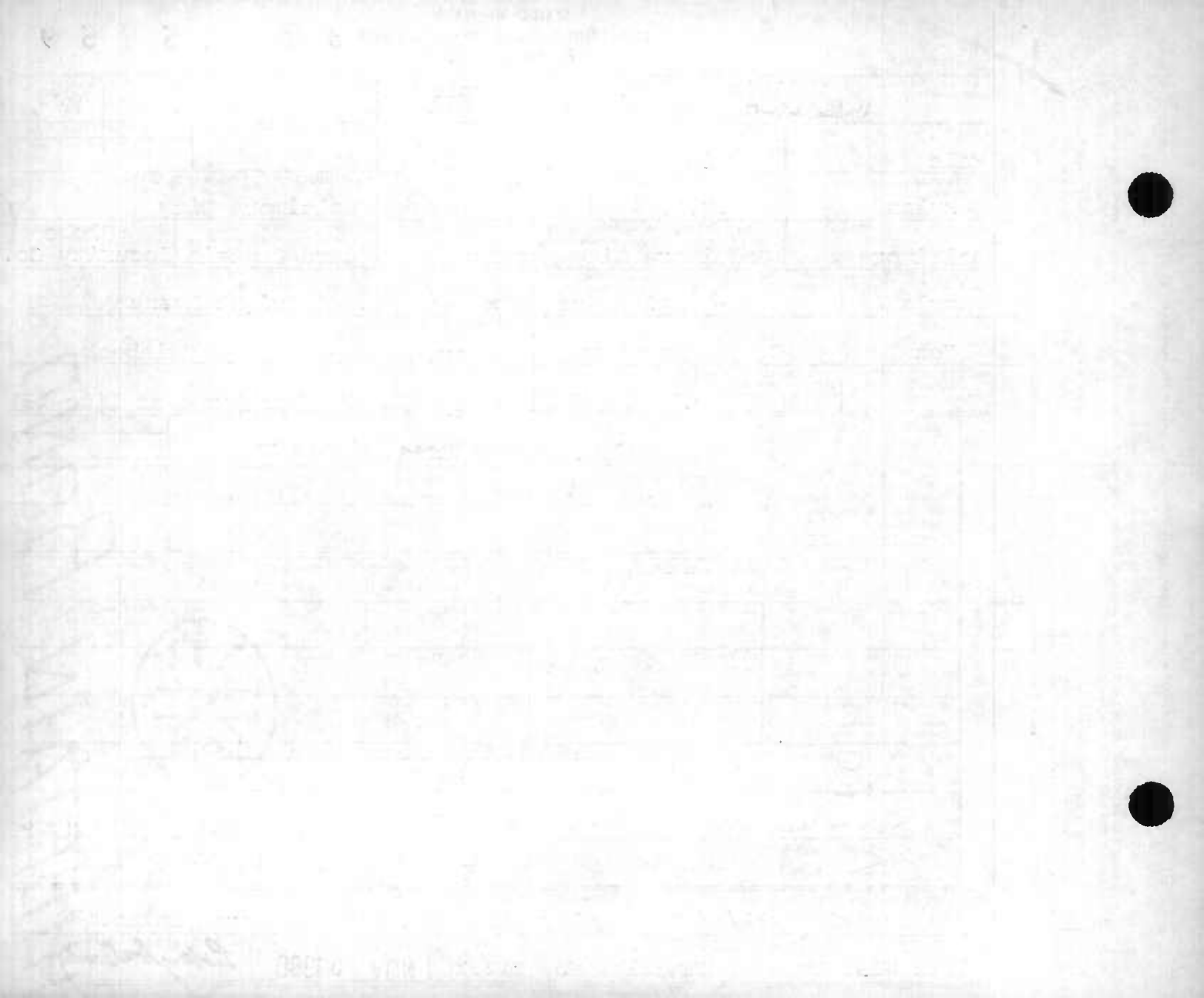
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 383-3000.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 5 5 9  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR 10 29 80		2b. HOUR 10:30 P.M.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William T. Kessler		3. SEX Male		4. RACE White	
5. DATE OF BIRTH MONTH DAY YEAR 4 30 1923		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
8. IF UNDER 24 HRS. HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		13. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
14. CITY OR TOWN OF DEATH Baltimore		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard Captain	
17. KIND OF BUSINESS OR INDUSTRY Globe Security Co.		18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore		19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. STREET ADDRESS 5046 Wright Avenue		21. FATHER'S NAME FIRST MIDDLE LAST John C. Kessler		22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Beinback	
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		24. SOCIAL SECURITY NO. 215-14-8368		25. INFORMANT ADDRESS Theresa M. Kessler (same as line 13)	
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4148 Cardiopulmonary arrest		27. DUE TO, OR AS A CONSEQUENCE OF (b) Electromechanical dissociation		28. DUE TO, OR AS A CONSEQUENCE OF (c)	
29. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) history of multiple myocardial infarctions		30. DATE OF OPERATION 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED 19b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
35. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		37. LOCATION STREET CITY OR TOWN COUNTY STATE	
38. I certify that (I) (this hospital) attended the deceased from 10/29/80 to 10/29/80, that (I) (we) lost saw the deceased alive on 10/29/80, and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		39. SIGNATURE S. WALDEN		40. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
41. PHYSICIAN'S NAME (TYPE OR PRINT) S. WALDEN		42. ADDRESS Baltimore City Hospital		43. DATE SIGNED 10/29/80	
44. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		45. DATE 11/1/80		46. NAME OF CEMETERY OR CREMATORY Holly Hill Mem.	
47. LOCATION CITY OR TOWN COUNTY STATE White Marsh, Balto. MD		48. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222		49. DATE REC'D. BY REGISTRAR NOV 5 1980	
50. REGISTRAR'S SIGNATURE		51. REGISTRAR'S SIGNATURE		52. REGISTRAR'S SIGNATURE	



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0	2 5 5 6 0	
1. FOR STATE REGISTRAR			REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST (Emmett) MIDDLE LAST EMMITT E. KIDD			2a DATE OF DEATH MONTH DAY YEAR OCTOBER 13, 1980				2b HOUR 11:12 AM					
3 SEX Male		4 RACE B		5 DATE OF BIRTH MONTH DAY YEAR 6 16 23		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ala.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD						
10 CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Homes & Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1403 E. Baltimore St.			
14 FATHER'S NAME FIRST MIDDLE LAST Charlie Kidd				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lovely Datcher								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-14-8080		17 INFORMANT Wilson Kidd			17 ADDRESS 2346 Barkley St.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST 410- DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from OCTOBER 13, 1980, to OCTOBER 13, 1980, that (I) (we) lost saw the deceased alive on OCTOBER 13, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE A. F. Nazemi M.D.						DEGREE M.D.			22c. DATE SIGNED 10/13/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. F. NAZEMI, M.D.						22e ADDRESS 100 N. BROADWAY BALTIMORE, MD 21231						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 10/17/80		23c NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.			23d LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.				
24 FUNERAL DIRECTOR NAME Wm C March F/H						ADDRESS 1101 E. North Ave.			25a DATE REC'D. BY REGISTRAR OCT 14 1980		25b REGISTRAR'S SIGNATURE R. J. Kelly	

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Handwritten signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRY J. KIDD			2a. DATE OF DEATH MONTH DAY YEAR 10 12 80			2b. HOUR 13 40 <sup>A</sup> M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 03 30 04		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ILLUSTRATOR		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN HALETHORPE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH W. KIDD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE MAE ANDREWS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 216-44-3595		17. INFORMANT ADDRESS GERTRUDE K. KIDD 4600 REHBAUM AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from 10/11/80 to 10/12/80, that (I/we) lost saw the deceased alive on 10/12/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death.								
22b. SIGNATURE Ashok Kumar Chopra M.D.			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/12/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. CHOPRA			22e. ADDRESS ST. AGNES HOSPITAL 900 CATON AVE. BALTIMORE MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-15-80		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE PIKESVILLE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.			ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

10-2-59

UNITED STATES GOVERNMENT  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

PLANT  
INDUSTRY



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO. 8 0 2 5 5 6 2									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN THOMAS KILLIAN, SR.						2a. DATE OF DEATH MONTH DAY YEAR 10 9 80		2b. HOUR M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5507 Anthony Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker		12b. KIND OF BUSINESS OR INDUSTRY Beth, Steel	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5507 Anthony Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST James - Killian				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth - Fuka					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT 5507 Anthony Ave. Barbara Killian, wife, 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Bronchogenic Carcinoma</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/5/80</u> , 19 <u>80</u> , to <u>10/8/80</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/8/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Rouben Jiji</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rouben Jiji, M.D.				22e. ADDRESS University Hospital, 22 S. Greene St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/13/80		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		3331 Brehms Lane Baltimore, Md. 21213		25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE <u>Ruby McCreedy</u>			

5 8 1 2 3

8

DRUGS AND  
MEDICAL SUPPLIES  
AND CHEMICALS



100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8025563			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>AUTUMUS - KING</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 2 80</b>		2b. HOUR <b>11 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET/GRAVEDIGGER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>6029 Harristown Road</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE KING</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NELLIE MURPHY</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>218-22-9303</b>		17. INFORMANT <b>SP</b>		ADDRESS <b>6029 Harristown Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac tamponade</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pericardial effusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic carcinoma of left lung</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <b>10/11</b> 19 <b>80</b> , to <b>10/2</b> 19 <b>80</b> , that (I) (we) lost <b>saw the deceased alive on 10/2</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William J. Hicken M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/2/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM J. HICKEN M.D.</b>		22e. ADDRESS <b>900 CATON AVE BALTIMORE MD 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>BURIAL</b>		23b. DATE <b>10/6/78</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTERN STAR</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CATONSVILLE, Maryland</b>	
24. FUNERAL DIRECTOR <b>C. Brown</b>		ADDRESS <b>C. F. H. 12024 Montrose</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia H. Hickey</b>	



U.S. AIR FORCE

BALTIMORE CITY

DEPARTMENT OF DEFENSE

BALTIMORE CITY

U.S.

DEPT. OF DEFENSE

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DEPARTMENT OF DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/791- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 2 5 5 6 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Clarence W. King Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Oct. 4, 1980</b>			2b. HOUR <b>3:58 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 20, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN MUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospitals</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>			13c. COUNTY <b>Howard</b>		13d. CITY OR TOWN <b>Ellicott City</b>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence King</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alma Turner</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215 07 5654</b>		17. INFORMANT ADDRESS <b>Clarence W King Jr. 2638 Wellworth Way 21794</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive A.S.C.U.D.</b>	
		DUE TO, OR AS A CONSEQUENCE OF (c)	
		<b>20 years</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Lymphoma, nodular, poorly differentiated</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-16</b> , 19 <b>80</b> , to <b>10-4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9-8</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Thomas F. Herbert, M.D.</b>		22c. DATE SIGNED <b>10.5.80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas F. Herbert, MD</b>		22e. ADDRESS <b>Ellicott City, Md. 21043</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct 7, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard, Maryland</b>	
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24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry H Witzke 4112 Columbia Road Ellicott City</b>		25. DATE REC'D. BY REGISTRAR <b>OCT 6 1980</b>		26. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>	
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BP



Oct. 4, 1930 Clarence M. King

Wife

U.S.A.

Belmont

Belmont

Clarence King

215 W. 10th St. Clarence M. King

215 W. 10th St. Clarence M. King

215 W. 10th St. Clarence M. King

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215 W. 10th St. Clarence M. King

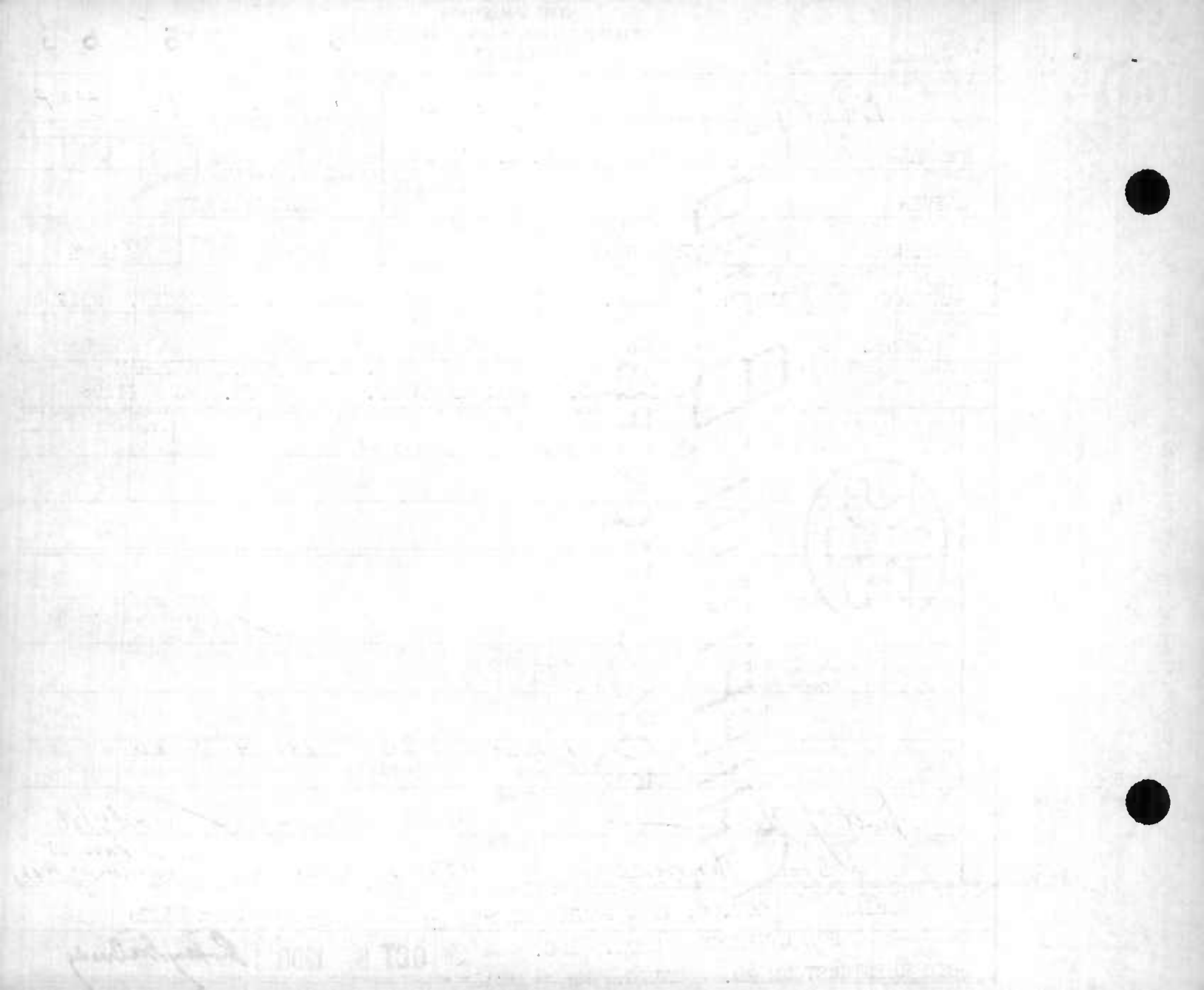
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 0 2 5 5 6 5				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
BETTY KIPNESS					10. 4. 80				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
FEMALE		Ca UCASIAN		APR. 29, 1905		75 YRS.		330 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
LATVIA		USA				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		MERCY HOSPITAL				HOUSEWIFE		AT HOME	
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MARYLAND		BALTO.				7901 BROOKFORD CIR. #21208			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
SAMUEL HYMAN				FRED A BAILA UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO				062-14-5398		MRS. FLORENE SCHWARTZMAN 7611 CARLA RD. BALTO., MD 21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 4</u> , 19 <u>80</u> , to <u>OCT 4</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>OCT 4</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<i>Scott Henderson</i>								10/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
SCOTT HENDERSON				MERCY HOSPITAL 361 ST PAUL ST. BALTIMORE MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		OCT. 6, 1980		BALTIMORE HEBREW		REISTERSTOWN BALTO MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						OCT 8 1980		<i>Ruby K. Brady</i>	

MEDICAL CERTIFICATION



See item G-22 film G 550 12/4/80 STATE OF MARYLAND

1- FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80 25566

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH DAY YEAR		2b. HOUR	
Mary Elizabeth Kirchner				10 18 80						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR
Female	White	Sept. 15, 1922		58 YRS.					10 18 80		3:22 p.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		6611 Eastern Parkway				Homemaker					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6611 Eastern Parkway			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Charles Raymond Surret				Nellie T. Quarles							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				218-14-4766		Ms. Mary Frances Kirchner same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
5718 IMMEDIATE CAUSE (a) Fatty liver											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION					
						STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Margarita A. Korell, M.D.				Assistant				10-19-80			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Margarita A. Korell, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		Oct. 21, 1980		Druid Ridge		Pikesville Balto. Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck Inc. Baltimore, Maryland				OCT 20 1980				R. J. Ruck			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Page 1  
of 1  
1911

1911

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 6 7

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>John James Kitko Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 20, 1980</b>		2b. HOUR <b>2:21p<sub>M</sub></b>						
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 12, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Id.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>				12a. USUAL OCCUPATION (GIVE WORK OR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR <b>MD</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Id.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>910 S. Boulton St.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John James Kitko Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Kitko</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-05-6828</b>			17. INFORMANT ADDRESS <b>Rose Kitko 910 S. Boulton St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>1619</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Squamous Cell Carcinoma of the Larynx</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Squamous Cell Carcinoma of the Larynx</b> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joseph Gent</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>10/20/1980</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph Gent, M.D.</b>			22e. ADDRESS <b>c/o Maryland General Hospital</b>								
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>			23b. DATE <b>10-23-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION <b>Baltimore City, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Helma R. Holmann</b>			3218		25a. DATE REC'D. BY REGISTRAR <b>OCT 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia K. [Signature]</b>				

35  
48  
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1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



October 20, 1976

John

John

with one day

Medical (Medical)

John

Respiratory failure

Summary of the history

John (John)

John

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 6 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>NICHOLAS GEORGE KITRINOS</b> <b>Nicholas G. Kitrinis</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 03, 1980</b>		2b. HOUR <b>6:57pm</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 14, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS MIN. <b>71 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CHIOS, GREECE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>The Johns Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BARBER.</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE KITRINOS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RENA ?</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II</b>		17. INFORMANT <b>GEORGE L. KITRINOS</b>		ADDRESS <b>1817 WEYBURN RD. BALTO. 21206, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ischemic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>congestive heart failure</b>							
19a. DATE OF OPERATION <b>9/19/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Coronary artery disease ischemic valvular disease</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERWAY <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NA</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NA</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> IN WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NA</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NA</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> , 19 <b>80</b> , to <b>10/3</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10/3</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Wm. A. Crawley, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/3/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm. A. Crawley, MD</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-7-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>KENWOOD AVE. FULLERTON, BA. CO., MD</b>	
24. FUNERAL DIRECTOR NAME <b>Charles S. Seiler &amp; Son Inc.</b>				6224 EASTERN AVE. BALTO., 21224, MD.		25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



RECEIVED  
FEB 11 1963

NY

CLERK

TO: DIRECTOR, FBI (100-374301)  
FROM: SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the medical examiner, page 3 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 6 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry P. Klemkowski				2a. DATE OF DEATH MONTH DAY YEAR Sep. 10 12 80		2b. HOUR 754 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 - 06 02		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. Balto. Gen'l. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner, Restaurant		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS 1034 E. Fort Ave. Balto. Md.	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Klemkowski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Tilicki			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 216-32-6101A		17. INFORMANT ADDRESS Mr. Irvin Klemkowski, 300 12th. Ave. Bk. Park			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac asystole 5070 DUE TO, OR AS A CONSEQUENCE OF (b) possible extension of myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) stress associated w aspiration pneumonia 6 days APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. ? 10 min.							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) cardia cerebrovascular accident
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 29, 19 80, to OCT. 12, 19 80, that (I) (we) last saw the deceased alive on OCT. 12, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Barbara A. Fretwell MD				DEGREE MD		22c. DATE SIGNED OCT. 12 '80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA A. FRETWELL				22e. ADDRESS c/o S. Balto. Gen. Hosp. 3001 S. Hanover St. BALTO, MD. 21230			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Oct. 16, 1980		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Maryland	
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave. Balto. Md.				25. DATE REC'D BY REGISTRAR OCT 14 1980			

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Items #18a-22a Film G548

10/29/80 STATE OF MARYLAND

1- FOR  
STATE  
REGISTRAR

rc

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25570

1. DECEASED NAME (TYPE OR PRINT) <b>Delores V. Klingenstein</b>			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 10 5 19 80			2b. HOUR M
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR 7/19/34	6. AGE (IN YEARS) LAST BIRTHDAY 46 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 5 19 80
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>1523 Docksbury Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>W. R. Brown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stella Gibson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. William Powers, Towson, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot wound of head</b> <b>Gun: Handgun</b> 9550 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:10 P.M. 10/5/1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Found with self inflicted wound</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>at home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1523 Docksbury Rd. Towson Balto. Co., Md.</b>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Heart disease</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>H.R. Guard</b>		TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>10/6/80</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn Street, Balto., MD 21201</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/8/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Henry W. Jenkins &amp; Sons Co. 4905 York Road Balto., Md. 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>

08/09/2017  
Henry W. Johnson & Son CO.  
1000 Woodlawn

nr [y] 100, nr [f] 100 W

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 7 1 REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR				2b HOUR			
JOSEPH W. KNELL								10-19-80				7:55 AM			
3 SEX				4 RACE				5 DATE OF BIRTH MONTH DAY YEAR				6 AGE (IN YEARS LAST BIRTHDAY)			
Male				White				10 21 11				68 YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				U.S.A.								BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY			
Baltimore				South Baltimore General Hospital				Dye setter				Vulcan Hart Corp.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a STATE				13b COUNTY				13c CITY OR TOWN			
Maryland				Baltimore				Baltimore				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e STREET ADDRESS				12130			
Joseph				Irene				1713 Harmon Ave. Balto., Md.							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS			
Yes				W W 11				Elizabeth M. Knell				Catonsville, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <u>Oat cell carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>9/25</u> 19 <u>80</u> , to <u>10/19</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/19</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE <u>Barbara A. Cowley MD</u>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 10-19-80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA R. COWLEY				22e ADDRESS South Baltimore General Hosp, 3001 S. Hanover St.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION CITY OR TOWN COUNTY STATE			
Burial				10-23-80				Loudon Park Cemetery				Baltimore Maryland			
24 FUNERAL DIRECTOR NAME				ADDRESS				DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Hubbard Funeral Home, Inc.				4107 Wilkens Ave. Balto., Md. 21229				OCT 21 1980				Barbara A. Cowley			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rudessia W Knight			2a. DATE OF DEATH MONTH DAY YEAR 10 15 80			2b. HOUR 1635 hr.					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 15 27		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) W of Maryland hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. STREET ADDRESS 321 N Carey St.				
14. FATHER'S NAME FIRST MIDDLE LAST Not available			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N. A.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-20-5968		17. INFORMANT Mr. James Flemings Face sheet 321 N. Carey St				ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory arrest 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Diffusely metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Sever hyperthermia											
19a. DATE OF OPERATION 160 d ago			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast Cancer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/1/80, 19____, to 10/15/80, 19____, that (I) (we) last saw the deceased alive on 10/15/80, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur F. Woodward, Jr. MD					DEGREE Resident. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/15/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur F. Woodward, Jr.					22e. ADDRESS 22 S. Greene St. Baltimore Md.						
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 10-21-80		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Landsdown Md.				
24. FUNERAL DIRECTOR NAME Joseph L. Russ					ADDRESS 2222 W. North Ave.			25a. DATE REC'D. BY REGISTRAR OCT 20 1980		25b. REGISTRAR'S SIGNATURE L. J. Kennedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 5 5 7 3									
1. FOR STATE REGISTRAR		REG. NO.																	
I. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Isidore						KNOBLER		October 7, 1980										6:46A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS									
MALE		WHITE		APR. 6, 1914 <sup>R</sup>		66		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
ROMANIA		USA				Baltimore City												MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK, TRADE, HOBT, OR WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		Maryland General Hospital		MERCHANT		RETAIL													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
MARYLAND				BALTIMORE						201 E. HEATH ST.								#21230	
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST									
SAMUEL				KNOBLER		LISA		LIBBY		UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		215-42-2325		MRS. LORA KNOBLER		201 EAST HEATH ST. BALTO., MD												21230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Of The Colon</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Diabetes Mellitus</u>																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 19, 1980</u> to <u>October 7, 1980</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 7, 1980</u> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.																			
22b. SIGNATURE <u>Joseph A. Gent</u>		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-7-80															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Gent, M.D.		22e. ADDRESS c/o Maryland General Hospital																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
BURIAL		OCT. 8, 1980		ADATH ISRAEL		BALTIMORE MARYLAND													
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
6010 REISTERSTOWN RD. BALTO., MD 21215		OCT 14 1980		<u>Patricia K. Brady</u>															

REPORT OF THE CHIEF OF MEDICAL SERVICE  
FOR THE YEAR 1960

1. **General Information**

2. **Medical Service**

3. **Medical Administration**

4. **Medical Education**

5. **Medical Research**

6. **Medical Statistics**

7. **Medical Facilities**

8. **Medical Personnel**

9. **Medical Supplies**

10. **Medical Services**

11. **Medical Research**

12. **Medical Statistics**

13. **Medical Facilities**

14. **Medical Personnel**

15. **Medical Supplies**

16. **Medical Services**

17. **Medical Research**

18. **Medical Statistics**

19. **Medical Facilities**

20. **Medical Personnel**

21. **Medical Supplies**

22. **Medical Services**

23. **Medical Research**

24. **Medical Statistics**

25. **Medical Facilities**

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27. **Medical Supplies**

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98. **Medical Personnel**

99. **Medical Supplies**

100. **Medical Services**

Continuation of The Report

Discharge Statistics

1. **General Information**

2. **Medical Service**

3. **Medical Administration**

4. **Medical Education**

5. **Medical Research**

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99. **Medical Supplies**

100. **Medical Services**

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 7 4

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
ALICE O. KNOWLES			10/27/80			4:00a M			
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
FEMALE	WHITE	July 8, 1910	70 YRS			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY			
PENNA.	U.S.A.		BALTIMORE CITY MD			OWN HOME			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
1	JOHNS HOPKINS HOSPITAL		HOUSEWIFE			OWN HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
JAMES A. O'KEY			LANE ANNE WEIR						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			190-09-3480			JAMES A. KNOWLES, SAME AS 13c.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 1889									
DUE TO, OR AS A CONSEQUENCE OF (b) Subarachnoid Hemorrhage									
DUE TO, OR AS A CONSEQUENCE OF (c) Stroke									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/4, 1980, to 10/27, 1980, that (I) (we) last saw the deceased alive on 10/27, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
[Signature]						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10/27/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
DAVID A. FRANKLIN						James Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
CREMATION			10/31/1980		DELMARVA CREM.		LEWIS SUSSEX CO. STATE		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			
Bill Baker - Bounds, Salisbury Md.						OCT 31 1980			
25b. REGISTRAR'S SIGNATURE									
[Signature]									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued, it is the responsibility of the funeral director to complete and file it with the State Dept. of Health and Mental Hygiene prior to the burial or cremation. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows an injury or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL CLERK: This is a duplicate of the original certificate. The law requires that the original certificate be retained by the hospital of attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then give the certificate to the State Dept. of Health and Mental Hygiene for filing. Do not write on it.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 7 5

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FELIZABETH B. KOCHER		OCTOBER 15, 1980		01:18 PM	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		Mar. 8th, 1909	
6. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Balto. Md.		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (IF NOT MONTHLY OR YEARLY WORKING LIFE)	
Balto City		THE JOHNS HOPKINS HOSPITAL		Homemaker	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Carroll		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS	
FIRST MIDDLE LAST Clarence Bye		FIRST MIDDLE LAST Mary Jane Schorr		2333 Carrollton Rd. 21025	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS	
NO		214-05-3187		David B. Fyfe-109 E. Main St. Westminster	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic shock</u> <u>5712</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholic liver disease</u> (c) <u>Pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/6/80</u> , 19 <u>80</u> , to <u>10/15/80</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/15/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>John A. Abben</u>		M.D.		10/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
A. Abben		Johns Hopkins Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		10/16/80		Greenmount Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Balto City		OCT 22 1980		<u>Henry H. H. H.</u>	
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. CITY OR TOWN	
Mitchell-Wiedefeld Home-6500 York Rd. 21212				Balto City	

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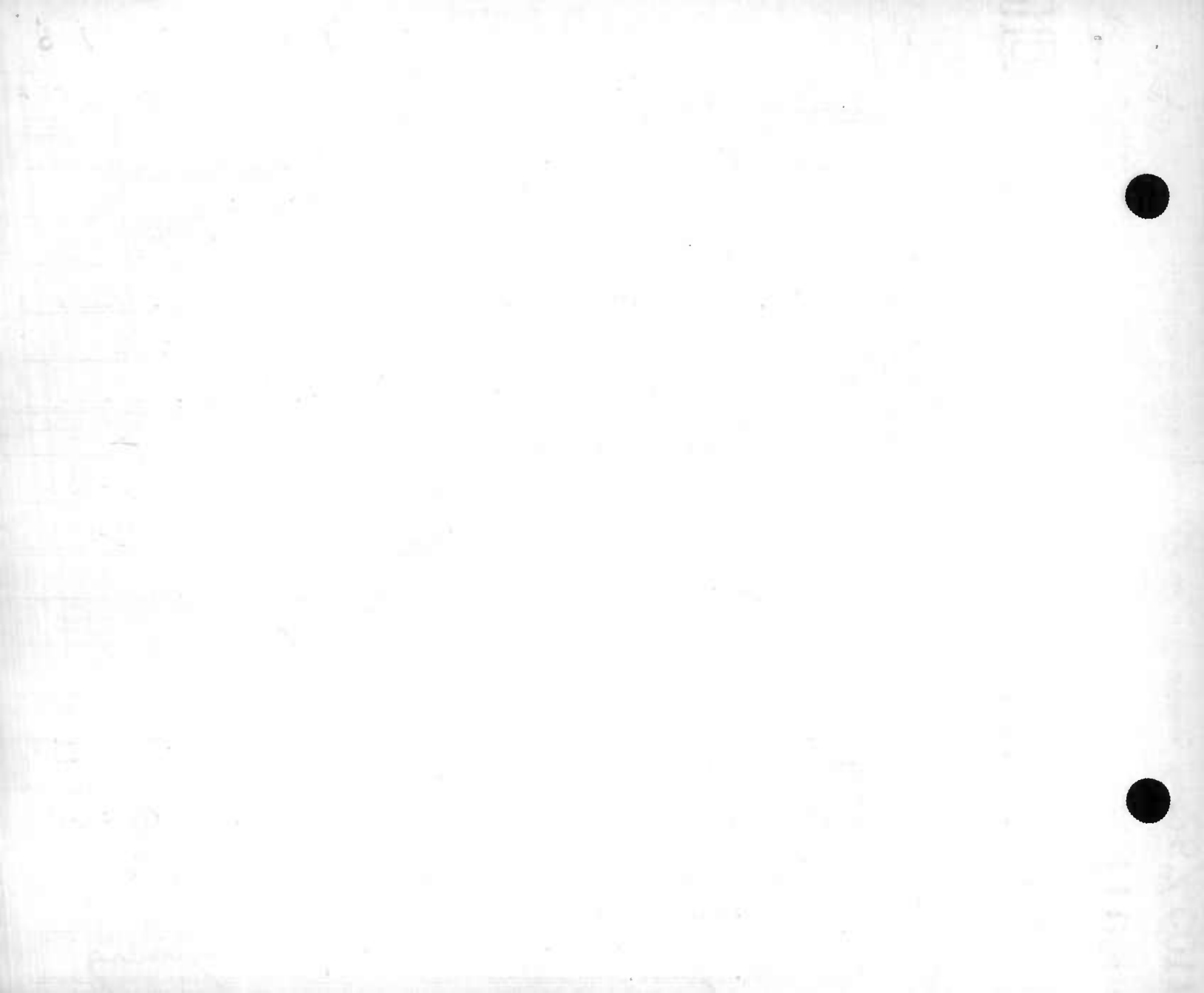
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 5 5 7 6		
1. FOR STATE REGISTRAR		REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)		FIRST JULIUS		MIDDLE Y.	LAST KOLODNER		2a. DATE OF DEATH		MONTH 10	DAY 15	YEAR 80	2b. HOUR 10 55 AM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH JAN. 4, 1900 DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.						
10. BALTIMORE DEATH X MARYLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROPRIETOR		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE						
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2422 BRAMBLETON RD. #21209				
14. FATHER'S NAME FIRST PHILIP		MIDDLE		LAST KOLODNER		15. MOTHER'S MAIDEN NAME FIRST GERTRUDE		MIDDLE UNKNOWN		LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-32-6376		17. INFORMANT MRS. SARAH KOLODNER		2422 BRAMBLETON RD. BALTO., MD 21209						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 2866 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>GT bleeding</u> (c) <u>disseminated intravascular coagulation</u> 12-18h 12-18h										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-18h		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Lymphoma</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> 19 <u>80</u> to <u>10/15</u> 19 <u>80</u> , that (I) (we) saw the deceased alive on <u>10/15</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>Jonathan Levi</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10/15/80</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jonathan Levi</u>		22e. ADDRESS <u>Sinai Hospital, Belvedere at Green Spring</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 16, 1980		23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL		23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY		STATE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25. DATE REC'D. BY REGISTRAR OCT 22 1980		26. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>						

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DHMH-16 20M  
(VRA 15, 4) 7/78



TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				80 25577 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT)				2b. HOUR			
FIRST MIDDLE LAST				10 12 80 900 A-M			
3 SEX				4 RACE			
FEMALE				CAUC.			
5 DATE OF BIRTH MONTH DAY YEAR				6 AGE (IN YEARS LAST BIRTHDAY)			
09 01 04				76 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
Greece				Greece			
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
BALTIMORE				RESTAURANTEUR			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12b. KIND OF BUSINESS OR INDUSTRY			
SO. BALTIMORE GENERAL HOSP.				Restaurant			
13a. STATE				13b. COUNTY			
MD.				BALT.			
13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
NICK ZARAFONETIS				Dimitri Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
NO				213-38-9638			
17a. INFORMANT				17b. ADDRESS			
Mr. Peter Kootsikis				5916 Linthicum Lane, Linthicum, Md. 21090			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Pulmonary arrest</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) <u>Supra</u>			
				(c) <u>Due to, OR AS A CONSEQUENCE OF</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
				P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED			
				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> 19 <u>80</u> to <u>10-12</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE			
22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)			
10/12/80				Sandra Lynn Howard M.D.			
22e. ADDRESS				22f. PHYSICIAN'S NAME (TYPE OR PRINT)			
300 S. Hanover St.				Sandra Lynn Howard M.D.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				Oct. 14, 1980			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Greek Orthodox Cent.				Baltimore Co. Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
McCutty Funeral Home 237 E. Patapsco Ave. Balto. Md.				25b. REGISTRAR'S SIGNATURE			
25c. DATE				25d. REGISTRAR'S SIGNATURE			
14 1980				D. J. H. H. H.			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	25578
FOR 1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Enma Marie Koppelman</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>October 26 1980</b>			2b. HOUR <b>9:35A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 18 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>					13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William F Christ</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-36-8312</b>		17. INFORMANT ADDRESS <b>Emily L. Barger 3804 Parkside Drive</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>urosepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>urinary retention + catheterization</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Right Middle Cerebral Artery Stroke</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>fecal impaction, depression</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 wks.</u>		
									<u>2 mos.</u>		
									<u>2 mos.</u>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>October 16, 1980</u> to <u>October 26, 1980</u> , that (1) (we) lost saw the deceased alive on <u>October 25, 1980</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <b>October 26, 1980</b>	
22b. SIGNATURE <b>B. R. Houston</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. R. Houston, M.D.</b>				22e. ADDRESS <b>Union Memorial Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville Baltimore, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>				ADDRESS <b>7401 Belair Road</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 29 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara McCreedy</b>			

BP

Baltimore City

Baltimore City Union Medical Hospital

Chief Medical Officer

A. S. Housner, M.D.

INDICATED BY  
100-30808

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 7 9  
REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>VASILIKI KOSMAKOS</b>		2a. DATE OF DEATH MONTH <b>10</b> DAY <b>19</b> YEAR <b>80</b>		2b. HOUR <b>10:40 AM</b>
3 SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH <b>04</b> DAY <b>03</b> YEAR <b>93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Greece</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>				
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>Diacumakos</b> LAST <b>Demetra</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Demetra</b> MIDDLE <b>Georgoulis</b> LAST <b>Georgoulis</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>335-26-9382D</b>		17. INFORMANT <b>John Kosmakos, 4 Spinners Court, Apt. A, Randallstown, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>410-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PROB. MI.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASTHMA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>10-19</b> , 19 <b>80</b> , to <b>10/19</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10-19</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>A. JAIN</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/19/80</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. JAIN</b>		22e. ADDRESS <b>B. C. Hospital</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-25-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Panagias Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Vasilikon, Sparta, Lagonia, Greece</b>		23e. DATE REC'D. BY REGISTRAR <b>OCT 20 1980</b>		
24. FUNERAL DIRECTOR NAME <b>Nicholas T. Matthews, 302 Eastern Avenue, Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony Matthews</b>		

MEDICAL CERTIFICATION

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VASTINI KOTHA-KOTHA

10-11-60

Female (Lassam) of 48

Genetic Group X

Post-mortem Examination Report

1. Post-mortem Examination

2. Section and Examination

3. Results of Examination

4. Remarks

5. Signature

6. Date

7. Place

8. Remarks

9. Signature

10. Date

11. Place

12. Remarks

13. Signature

14. Date

15. Place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

DHMH-16 25M  
(VRA 15, 4) 1/79FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25580

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Jacob Kotzen</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 9 80</i>			2b. HOUR <i>8A</i> M	
3 SEX <i>male</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>07 07 83</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>97</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>CITY</i> MD.	
10 CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SELF-EMPLOYED</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>GROCCER</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>				13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>LABE KOTZEN</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH RACHAEL UNKNOWN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219 32 8573</i>		17 INFORMANT <i>MRS. SAMUEL KOTZEN</i> <i>3812 FORDS LA., APT. 202 BALTO., MD 21215</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardio-respiratory arrest</i> <i>1531</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Carcinoma pancreatic aden</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>GI bleed</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-28</i> 19 <i>80</i> to <i>10-9</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>from 10-9</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Mark L. Burson MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/9/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARK L. BURSON MD</i>				22e. ADDRESS <i>SINAI HOSP. - BALTO., MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>OCT. 10, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HEBREW YOUNG MEN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>	
24 FUNERAL DIRECTOR NAME ADDRESS <i>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 14 1980</i>		25b. REGISTRAR'S SIGNATURE <i>R. J. H. H. H.</i>	

MEDICAL CERTIFICATION

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*[Faint, illegible handwriting on lined paper]*

*[Handwritten signature]*

AR 7 REGISTRAR *[Signature]*

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#6,161, Film G549 11/5/80 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Henry M. Kowalewski		2a. DATE OF DEATH MONTH DAY YEAR 10 26 80		2b. HOUR 10:26 P	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 8 09		6. AGE (IN YEARS LAST BIRTHDAY) 79 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Government		12b. KIND OF BUSINESS OR INDUSTRY Retired
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 46 Dungarrie Road	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kowalewski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-44-9836 None		17. INFORMANT ADDRESS Mrs. Dora Kowalewski Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/24, 19 80, to 10/26, 19 80, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bich Thuy Duong		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BICH THUY DUONG		22e. ADDRESS ST AGNES HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/29/80		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Maryland		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Ricky Holbrook	
24. FUNERAL DIRECTOR NAME Witzke Funeral Home of Catonsville		ADDRESS 1630 Edmondson Avenue Catonsville, Maryland		25a. DATE REC'D. BY REGISTRAR OCT 27 1980	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE CITY

BALTIMORE ST. ADAMS HOSPITAL

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1 - FOR  
STATE  
REGISTRAR

(AKA AUGUSTA)

1. DECEASED NAME (TYPE OR PRINT) <b>ANASTASIA ANASTASIA</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10-29-80</b>		2b. HOUR <b>12:15 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 19 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Stripper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cigar Mfg.</b>
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>-</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>111 S. Chester St. City 21231</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Yurek</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unk.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-09-4509</b>		17. INFORMANT ADDRESS <b>Edward Kujawa 111 S. Chester St. 21231</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METABOLIC ACIDOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>IMPENDING GANGRENE RIGHT LEG</b> 2762					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <b>10-28-80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>IMPENDING GANGRENE RIGHT LEG</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-28</b> <b>19</b> <b>80</b> , to <b>10-29</b> <b>19</b> <b>80</b> , that (I) (we) last saw the deceased alive on <b>10-29</b> <b>19</b> <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>DR. K. Y. S. SNEYDY</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10-29-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. K. Y. S. SNEYDY, MD.</b>		22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 31 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>George A. Weber &amp; Sons Inc. 705 S. Ann St.</b>			
25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

Handwritten notes on lined paper, including a large circled 'B' and various illegible scribbles.

OCT 30 1980

Handwritten signature or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 2 5 5 8 4  
REG. NO.1. FOR  
STATE  
REGISTRAR1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
FRANCES B. Kozlowski2a. DATE OF DEATH MONTH DAY YEAR  
10 25 80  
2b. HOUR MIN.  
9 30 A.M.3. SEX FEMALE 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR  
12 10 97 6. AGE (IN YEARS LAST BIRTHDAY) 82  
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH  
BALTO., MD. U.S.A. BALTIMORE CITY MD.10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY  
BALTIMORE Hamilton Nursing Center Seamstress Sewing FactoryUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS  
MD. BALTIMORE YES NO 13 N. LUZERNE AVE.14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
THOMAS DERDA JOSEPHINE KAPELA16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 17. INFORMANT ADDRESS  
NO 213-10-6011 MILTON KOZLOWSKI 5412 HAMILTON AVE.18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe ASCVD with aneurysm  
4292 DUE TO, OR AS A CONSEQUENCE OF (b) Fr of both Hips - old with 4 months  
Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) severe emphysemas. Decubitus ulcers

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

22a. I certify that (I) (this hospital) attended the deceased from 8/4 19 77, to 10/25 19 80, that (I) (we) last saw the deceased alive on 10/7 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE DEGREE 22c. DATE SIGNED  
J. Fromm, M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 10/26/8022d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS  
J.W. FROMM, M.D. 8014 OLD HARFORD RD., BALTIMORE23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE  
BURIAL 10/28/80 ST. STANISLAUS CEM. BALTIMORE MD.24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
B. DABROWSKI YSON 2818 E. BALTIMORE ST. OCT 28 1980 [Signature]

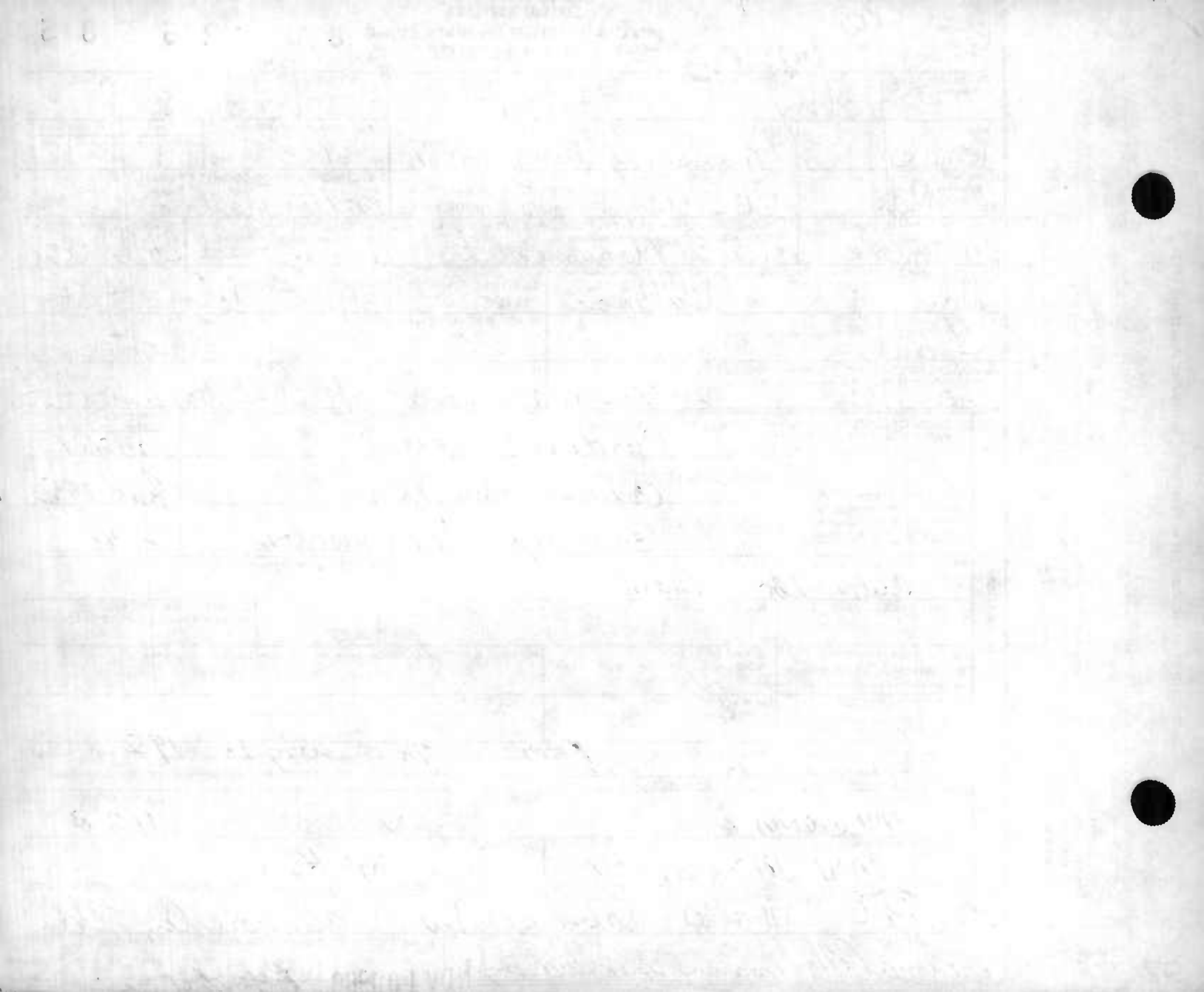


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 5 5 8 5	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Dorothy			Kraft			October 31, 1980			M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		Aug 25, 1919		61		MONTHS DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Baltimore City MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. KIND OF BUSINESS OR INDUSTRY		
Baltimore			3112 E. Monument St.			Crossing Guard			Baltimore City		
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			15. INSIDE CITY LIMITS?			16. STREET ADDRESS					
Md.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3112 E. Monument St.					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE								
Frank			Turkouski								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			214-03-2040			Raymond Kraft			3112 E. Monument St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11/5/80</u>	
4110 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Crown Artery Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>										<u>June 1980</u> <u>2 yr</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Pulm. Tbc - Inactive</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> 19 <u>78</u> to <u>Aug 15</u> 19 <u>78</u> , that (I) (we) lost saw the deceased alive on <u>8-15</u> 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
<u>M. W. JACOBSON</u>									<u>11-3-80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
M. W. JACOBSON MD			6810 Park Ave A								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			11-4-80			Oak Lawn Cms			Baltimore Co., Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Thelma Hoffmann			3218 Hudson St			NOV 10 1980			<u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 5 5 8 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VERNON E. KRAHL.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10-16-80.</b>		2b. HOUR <b>7-00<sup>P.</sup></b>	
3. SEX <b>male</b>		4. RACE <b>w.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-1-17.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>63</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GOOD SAMARITAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Professor/</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical Sch.</b>	
13a. STATE <b>Md.</b>				13b. COUNTY		13c. CITY OR TOWN <b>Balto.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward H. Krahl</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-30-5545</b>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4329</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intra Cranial Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Cirrhosis of Liver.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9-17-1980</b> to <b>10-16-1980</b> , that (I) (we) lost saw the deceased alive on <b>10-16-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>V. H. Reddy</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-16-80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VITTAL REDDY</b>				22e. ADDRESS <b>Good Samaritan Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>10/17/80</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McHenry</b>	

City. Baltimore  
Professor, Medical School  
Pennington  
221 N. Calverton Ave.

Baltimore  
No. 10  
Baltimore

10  
Baltimore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 8 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE L. KRAUSZ</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>OCT 2, 1980</b>				2b. HOUR <b>130</b>	
3 SEX <b>MALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11-18-04</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALT CITY</b> MD.			
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SBGH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FIREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3707 14th ST.</b>			
13a STATE <b>MD</b>		13b COUNTY <b>BALT CITY</b>		13c. CITY OR TOWN <b>BALT.</b>					
14 FATHER'S NAME FIRST MIDDLE LAST <b>George L. Krausz</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie - Rathell</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>212091892</b>		17 INFORMANT ADDRESS <b>Mrs. Shirley M. Krausz, Same as above</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY Arrest</b> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive double pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute myocardial infarction, left ventricle</b> <b>Generalized atherosclerosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (his hospital) attended the deceased from <b>9-10</b> <b>19 80</b> , to <b>10-2</b> <b>19 80</b> , that (I) (we) lost saw the deceased alive on <b>10-2</b> <b>19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b SIGNATURE <b>[Signature]</b>				DEGREE				22c DATE SIGNED <b>10-2-80</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>GILLINGHAM</b>				22e ADDRESS <b>SBGH 3001 S. Hanover ST</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Oct. 6, 1980</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>McUllly Funeral Home</b> ADDRESS <b>237 E. Patapsco</b>				25a DATE REC'D. BY REGISTRAR <b>OCT 7 1980</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>			



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 25588	
1. DECEASED NAME (TYPE OR PRINT) FRANCES W. KREHNBRINK					2a. DATE OF DEATH MONTH DAY YEAR 10-10-80			2b. HOUR 5:40 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 27 84		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS 380 Eagle Hill Road #21122				
13a. STATE Maryland		13c. CITY OR TOWN Pasadena									
14. FATHER'S NAME FIRST MIDDLE LAST William Winterbottom					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Moore						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216 48 1836		17. INFORMANT Thomas E. Krehnbrink			ADDRESS Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular arrhythmia</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD and possible Digoxin toxicity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <u>None</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (u) (this hospital) attended the deceased from <u>Oct 9</u> , 19 <u>80</u> , to <u>Oct 10</u> , 19 <u>80</u> , that (u) (we) last saw the deceased alive on <u>Oct 10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED Oct 10, 1980	
22b. SIGNATURE Bruce R. McCurdy M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE R. McCurdy M.D.					22e. ADDRESS 900 CATON AVE BALTIMORE MD 21229						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/13/80		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212					25a. DATE REC'D. BY REGISTRAR OCT 10 1980		25b. REGISTRAR'S SIGNATURE R. J. McCurdy				

MEDICAL CERTIFICATION



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 30M 2/80  
(VRA 15, 4)



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 5 5 8 9	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH E. KUEHN						2a. DATE OF DEATH MONTH DAY YEAR 10 14 80		2b. HOUR 2:35 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 28 90		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerical		12b. KIND OF BUSINESS OR INDUSTRY Insurance CO.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2810 E. Strathmore Ave,			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Henry Kuehn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Gleichman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-07-0522-A		17. INFORMANT ADDRESS 4021 Bordeaux Drive Northbrook, Ill. 60062							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> 431- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive cerebrovascular</u> (c) <u>Accident due to hemorrhage</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-11</u> , 19 <u>80</u> , to <u>10-14</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10-14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rosita R. Cruz M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-14-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rosita R. Cruz						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Oct. 16, 1980		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore --- Md.			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home						ADDRESS 6500 York Road Bal. Md.		25a. DATE REC'D. BY REGISTRAR OCT 17 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



Price, \$1.00  
Quantity, 1000  
Total, \$1.00  
Date, 10/10/50  
By, [Signature]  
To, [Signature]  
315-07-0527-1



315-07-0527-1  
10/10/50

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 5 9 0  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Ada Margaret Kuehne		MONTH DAY YEAR 10 08 80	
3. SEX		2b. HOUR	
Female		8:00 A.M.	
4. RACE		6. AGE (IN YEARS LAST BIRTHDAY)	
White		86 YRS.	
5. DATE OF BIRTH		IF UNDER 1 YEAR	
MONTH DAY YEAR 09 06 1894		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		Baltimore City MD.	
7b. CITIZEN OF WHAT COUNTRY?		12a. USUAL OCCUPATION	
USA		(TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH		Homemaking	
Baltimore			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Harford Gardens Convalescent			
13a. STATE		13b. COUNTY	
Maryland		Baltimore	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Fullerton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Jacob Mohr		FIRST MIDDLE LAST Matilda Spath	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
No		220-32-2927	
17. INFORMANT		ADDRESS	
Barbara M. Heil		4912 Ridge Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
DUE TO, OR AS A CONSEQUENCE OF (b)			
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
		Ava. 20 19 80 to Oct. 8 19 80	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 8 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Joy M. Zimmerman M.D.		22c. DATE SIGNED 10/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joy M. Zimmerman M.D.		22e. ADDRESS 3202 Harford Rd, Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		10/11/80	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Zion Cemetery		Golden Ring Baltimore Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Lassahn Funeral Home		OCT 14 1980	
ADDRESS 7401 Belair Road		25b. REGISTRAR'S SIGNATURE Anthony A. Cray Jr.	



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 9 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES RAYMOND KUES, SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 15, 1980</b>			2b. HOUR <b>1:15P.M.</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 3, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3915 HUDSON ST. # 21224.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF INDUSTRY <b>ASBESTOS WKRS. UNION #11</b>		
13a. STATE <b>MD.</b>			13b. COUNTY <b>-----</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3915 HUDSON ST. # 21224.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES KUES</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINNIE ?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-01-1105</b>		17. INFORMANT ADDRESS <b>617 GIFFORD LANE CHARLES R. KUES, JR. HEREFORD, 21111, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death <b>minutes</b> <b>years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive pulmonary disease</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>80</b> , to <b>July</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>July</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the body was not seen after death, so state.)										
22b. SIGNATURE <b>Richard Barnett M.D.</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/17/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD BARNETT</b>				22e. ADDRESS <b>4940 EASTERN AVE., BALTO., 21224, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-20-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>7401 GERMAN HILL RD. BA.CO., MD.</b>				
24. FUNERAL DIRECTOR NAME <b>Charles S. Guler &amp; Son, Inc.</b>				24b. ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>		

10-10-1964

**NAME:** Anastasia Kujawa Aka Augusta Kujawa

**DATE OF DEATH:** October 29, 1980

**PLACE OF DEATH:** Baltimore City

**SEE:** #80- 25583  
Baltimore City

DHMH 2485 - Vit. Rec.

THE  
OFFICE OF THE  
ATTORNEY GENERAL

STATE OF NEW YORK

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 5 9 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

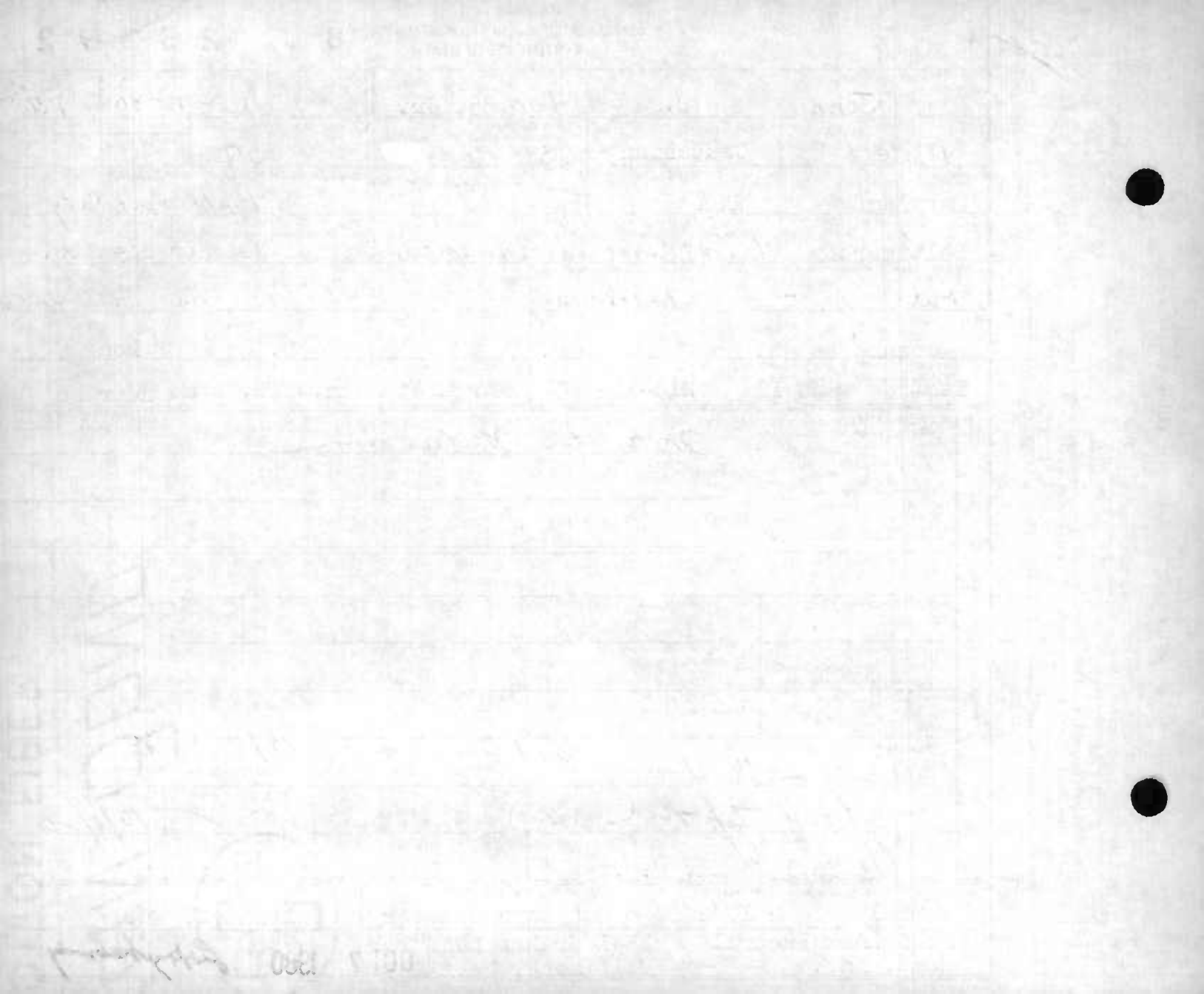
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
John		H.	Lamm, Jr.		10-1-80					1:30 PM	
3 SEX	4. RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	Caucasian		03-16-23		57 YRS		MONTHS		DAYS		
7 BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore City MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Union Memorial Hospital				Chief Weigher		Soya Co.			
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Md.					-		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
John H. Lamm, Sr.					Mary L.		Long				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17 INFORMANT ADDRESS				
Yes					WW II		215-14-0897 Margaret Lamm, wife, same address				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Melanoma</u> 1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>80</u> , to <u>10/1</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)											
22b. SIGNATURE					DEGREE					22c. DATE SIGNED	
<u>Yael Yokel</u>					M.D.					10/1/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
Yael Yokel, M.D.					Union Memorial Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			10/2/80		Oak Lawn Cemetery		Baltimore, Md.				
24 FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Shimunek Funeral Home, Inc.					3331 Brehms Lane Baltimore, Md. 21249		OCT 7 1980		<u>John H. Lamm</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use on the death certificate, the attending physician must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

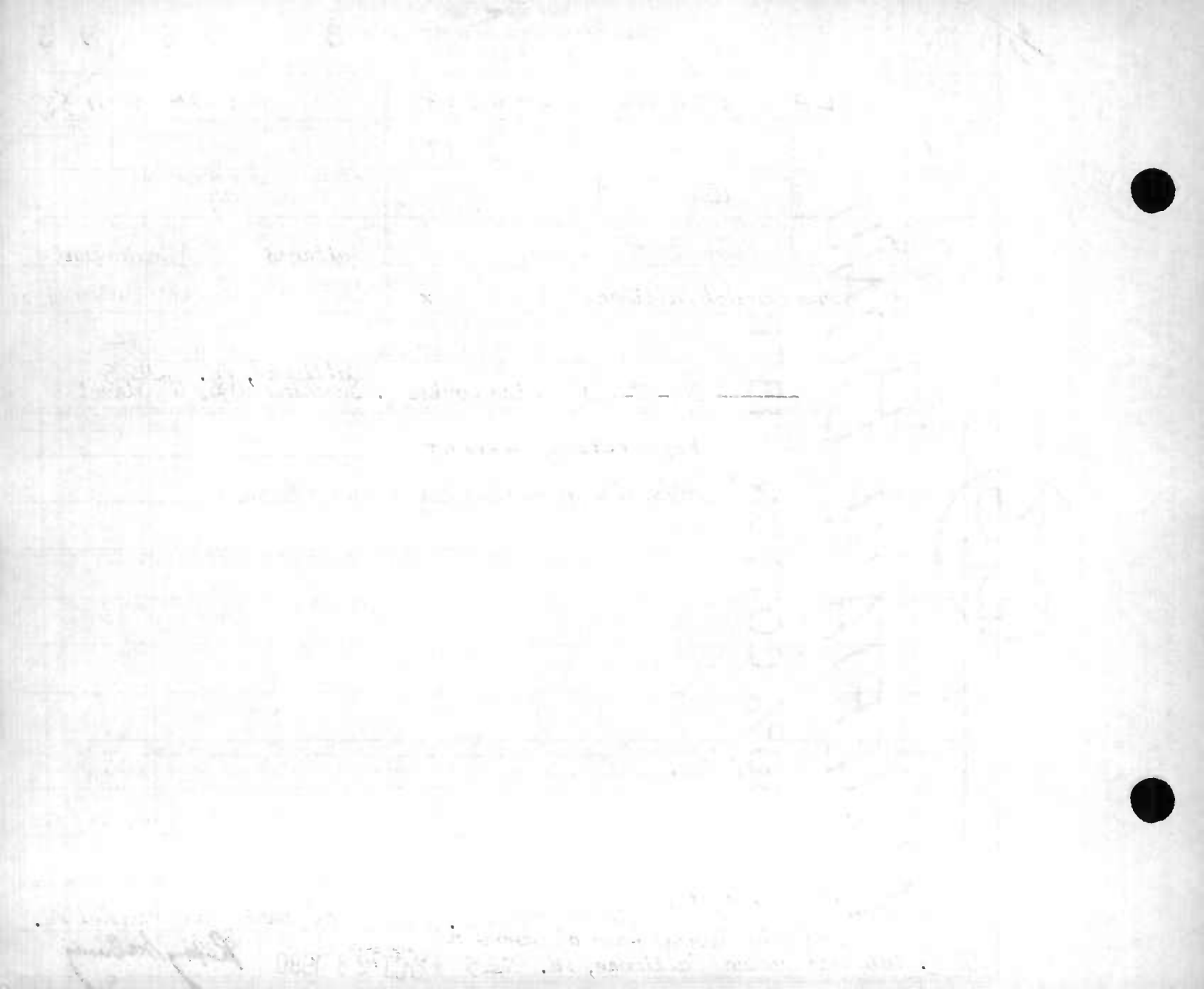


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 5 5 9 3			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
LULA		CARRIE		LANASA		OCT 26 80				11:58 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white		MONTH 1 DAY 27 1988		82 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD		USA				Baltimore City MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Johns Hopkins General						Waitress		Restaurant			
13a. STATE						13b. CITY OR TOWN		13c. STREET ADDRESS					
Md.						Anne Arundel Baltimore		Starmonde Lane Nursing Home					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Chas. I. Miller				Christine Schmidt									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT							
NO				219-22-4626		Miss Louise C. Scandina 4036 1/2 6th Street Baltimore, Md. 21225							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Massive pulmonary embolism</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/24/1980</u> to <u>10/26/1980</u> , that (I) (we) last saw the deceased alive on <u>10/26/1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
Stavrou								10/26/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
NICO S STAVROU				SBGH									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		10/30/80		Glen Haven Mem. Park		Glen Burnie Anne Arundel Md.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Mc Cully Funeral Home of Brooklyn 237 E. Patapsco Avenue Baltimore, Md. 21225				OCT 28 1980				Rafael McBrady					

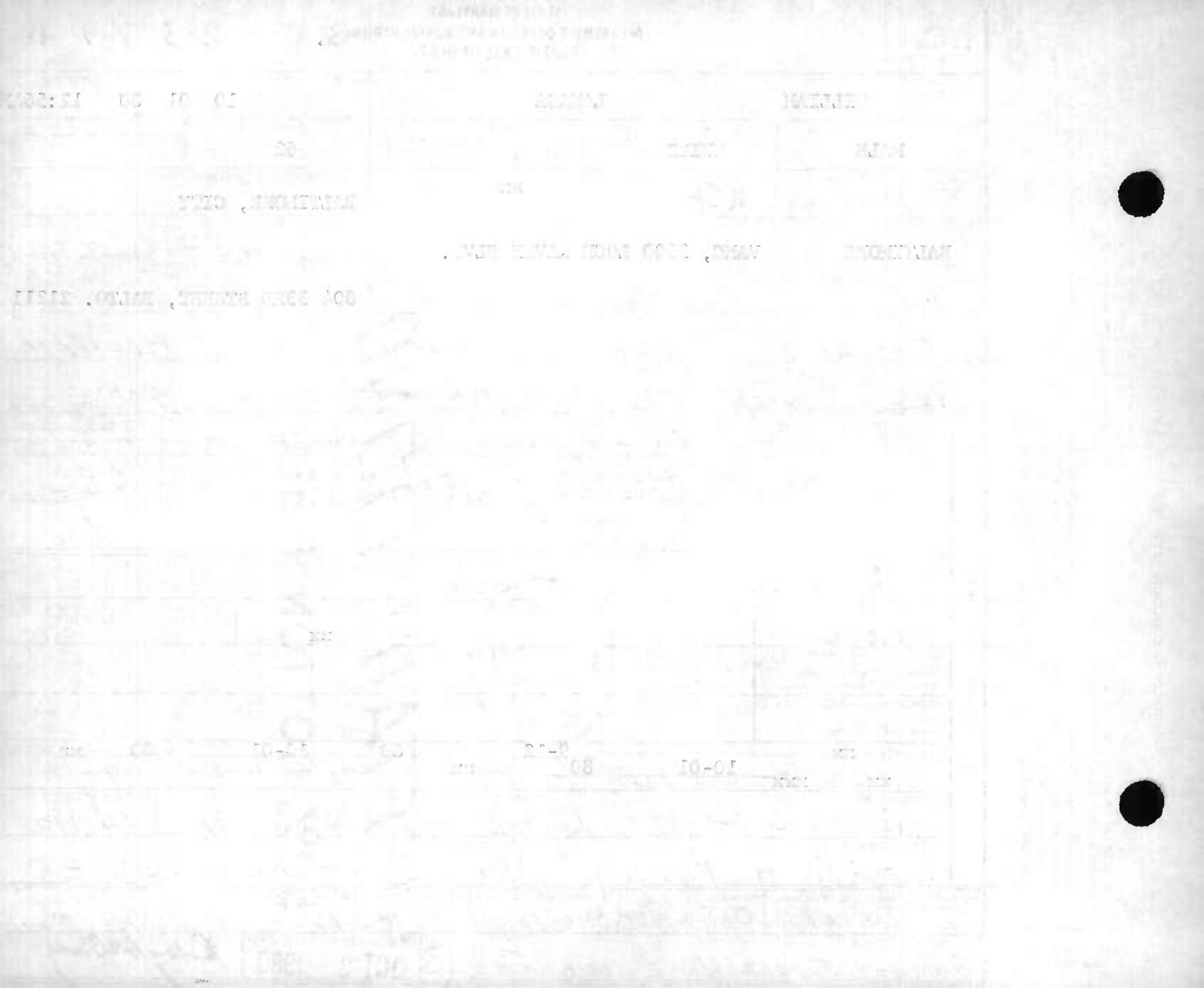


1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
WILLIAM		LANASA						10		01	80	12:56AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		MAY 18 1918		62		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		USA				BALTIMORE, CITY						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		VAMC, 3900 LOCH RAVEN BLVD.		CHAUFFEUR		SANITATION							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		804 33RD STREET, BALTO. 21211					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
MICHAEL		LANASA		MARY		E		MUELLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES		WWII		213 14 2115		ANNA G LANASA		SAME					
18. CAUSE OF DEATH		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
0389				Cardio pulmonary arrest				30 min					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)		Acidosis (metabolic)		2 hrs					
				(c)		Sepsis		8 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Cirrhosis, Renal Failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
none				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from 9-12 19 80 to 10-01 19 80, that (we) lost saw the deceased alive on 10-01 19 80, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
		Susan H. Prouty MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		10/1/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
SUSAN H. PROUTY		BALTO. VA MED. CENTER											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		OCT 4 1980		MORELAND MEM.		PARKVILLE BALTO. MD.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. SIGNATURE							
BURGEE FUNERAL HOME		3631 FALLS RD		OCT 2 1980		Susan H. Prouty							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 5 9 5

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILBUR H. LANE			2a. DATE OF DEATH MONTH DAY YEAR 10 22 80		2b. HOUR A. M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 31 03		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2502 MARBOURNE AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY BUGLE LAUNDRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 2502 MARBOURNE AVE.		14. FATHER'S NAME FIRST MIDDLE LAST WILBUR H. LANE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA R. PEACH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS GEORGE AIKEY 2502 MARBOURNE AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Heart myocardial infarction</i> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b): <i>Arteriosclerotic cardiovascular disease</i> (c): <i>Ischemic</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <i>5 min</i> <i>10 years</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Emphysema</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>10-21</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>S. Gehlert</i>				DEGREE		22c. DATE SIGNED <i>20 Oct 80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney R. Gehlert				22e. ADDRESS 4700 Pennington Avenue			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/24/80		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR OCT 23 1980		25b. REGISTRAR'S SIGNATURE <i>Anthony M. [Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 5 9 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Winnie Lancaster</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10-21-80</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-18-1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Key Circle Hospice</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maid</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Prine Geo. Greenbelt</b>		13c. STREET ADDRESS <b>7825 Mandan Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-68-7446</b>		17. INFORMANT ADDRESS <b>Mrs. Margurite Gates Same as #13c</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes Mellitus</b> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERAL months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>AK amputation left leg</b> <b>SEVERAL months</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. Ellsworth Cook</b> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>10-21-80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. Ellsworth Cook M.D.</b>				22e. ADDRESS <b>2431 Maryland Ave Balto. Md 21218</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>10/22/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1980</b>		25b. SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	25597
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William W. Langley Jr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>10 19 80</b>		2b. HOUR <b>5 4 M</b>			
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 8 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13e. STREET ADDRESS <b>2223 Cecil Ave.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William W. Langley Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eva Cole</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-12-5072</b>		17. INFORMANT ADDRESS <b>Samuel Langley 2223 Cecil Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asystole</b> 3453 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Brainstem displacement</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Status Epilepticus + electrolyte imbalance 2 days</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>											
19a. DATE OF OPERATION <b>NA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>NA</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>NA</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>NA</b>							
22a. I certify that (I, this hospital) attended the deceased from <b>10/16/80</b> 19 to <b>10/19/80</b> 19, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>10/19/80</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE <b>D. Carroll</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/19/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARROLL D. Carroll</b>				22e. ADDRESS <b>Union Memorial Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/24/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Nat'l Mem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel MD</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm. C. March F/H 1101 E. North Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

11-22-11

WASHINGTON CITY

WASHINGTON CITY

WASHINGTON CITY

D. Carroll

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 0 2 5 5 9 8					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eleanora D Laslo					2a. DATE OF DEATH MONTH DAY YEAR Oct 11 80					
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR Feb 8 1903		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7b. HOUR 10:56 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 524 N Charles				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md					13b. COUNTY Balt.		13c. CITY OR TOWN Balt.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John N Matthai					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adolphine Koepper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216 28 7405A		17. INFORMANT ADDRESS Betty Warner Dover Delaware						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 429.2 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Hypothyroidism Thrombocytopenia</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from MAY 21, 1980, to OCT 11, 1980, that (I) (we) last saw the deceased alive on AUG 16, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Walter R. Welzant MD				DEGREE		22c. DATE SIGNED OCT 13, 1980				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER R. WELZANT, MD				22e. ADDRESS MEDICAL AHS BLDG 422-25 BALTIMORE, MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 15 Oct 80		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Princes Georges CO. Md.				
24. FUNERAL DIRECTOR NAME William Crockett				ADDRESS Dover		25a. DATE REC'D. BY REGISTRAR OCT 27 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

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UNCLASSIFIED

OCT 27 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 0 2 5 5 9 9	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR
Richard John Lawton			October 14, 1980		5: A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	Dec. 14, 1920		59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
N.Y.	U.S.A.			Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	2201 Echodale Avenue		Beth. Steel- Clerk Typist		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Maryland			Baltimore	Balt., Md. 21214	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
Patrick Lawton			Elizabeth Sullivan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
Yes		WW II	Marie B. Lawton		
		065-12-0413	2201 Echodale Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>C.O.P.D. with chronic bronchitis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>February</u> 19 <u>80</u> , to <u>10/14</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9/25</u> 19 <u>80</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>				22c. DATE SIGNED 10/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Vuong Nguyen M.D.				22e. ADDRESS 1656 E. Belvedere Ave. Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		Oct. 17, 1980	Gates of Heaven		New York New York
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>
			OCT 15 1980		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The medical examiner must be notified of death immediately. The law requires that the death certificate be executed within 24 hours of death. The medical examiner must be notified of death immediately.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORA B. LEAKE				2a. DATE OF DEATH MONTH DAY YEAR 10/06/80			2b. HOUR 2:30a M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland				13b. COUNTY Balto.		13c. CITY OR TOWN Monkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William M. Bullitt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Iasigi					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 151-05-2729		17. INFORMANT ADDRESS Eugene W. Leake, Jr. Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>intractable hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>intracerebral tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lymphomatoid granulomatosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hours unknown unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N.A. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N.A.				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> , 19 <u>80</u> , to <u>10/6</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/6/80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Kenneth Rostacher MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH ROSTACHER						22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 10/7/80		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR OCT 7 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

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Green Mountain

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Contribution

Henry W. Jenkins & Son Co.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 5 6 0 1				
1. FOR STATE REGISTRAR										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM FRANKLIN LEARD							2a. DATE OF DEATH MONTH DAY YEAR 10 23 80 2b. HOUR A 9:30 M							
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR July 11, 1920			6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4605 Furley Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Checker			12b. KIND OF BUSINESS OR INDUSTRY Union				
13a. STATE Maryland							13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4605 Furley Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Walter - Leard					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria - Grimes									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT 5537 Todd Ave., 21206 Mrs. William Leard, dgtr-in-law,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>months</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>80</u> , to <u>10/23</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Robert A. Hartley, M.D.							DEGREE M.D.			22c. DATE SIGNED 10/27/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert A. Hartley, M.D.							22e. ADDRESS Union Memorial Hospital 200 E. 33rd Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/25/80		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.						
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.,							3331 Brehms Lane Balto., Md. 21218			25a. DATE REC'D BY REGISTRAR OCT 28 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

10-22-08

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

10-22-08



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8025602	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST ALEX		MIDDLE MILTON		LAST LEBAN		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 25, 1980		2b. HOUR 5 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 13, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6711 PARK HTS. AVE., APT. 208				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY RETAIL			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 6711 PARK HTS. AVE., APT. 208			
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL LEBAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULINE RUBIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. (IF YES, GIVE WAR OR DATES) WWII-ARMY		16c. SOCIAL SECURITY NO. 091-03-9697		17. INFORMANT MRS. ROSE LEBAN		6711 PARK HTS. AVE., APT. 208		#21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Seizure Discharge - TIA</u> <u>4599</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1968</u> , 19____, to <u>10/25</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Edward Kallins</u>				DEGREE				22c. DATE SIGNED 10/27/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EDWARD KALLINS				22e. ADDRESS 6000 PARK HTS. AVE. BALTO., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 27, 1980		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH		23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY MARYLAND		STATE	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR OCT 28 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

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1. *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue and red regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy in the form of ATP and NADPH.

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1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8-0 25603		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ADELAIDE M. LEBER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10 13 80</b>		2b. HOUR <b>3<sup>50</sup> A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 18, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Leber</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Tudor</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218 32 0321</b>		17. INFORMANT ADDRESS <b>Miriam C. McKean Balto., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic carcinomas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/13</b> , 19 <b>80</b> , to <b>10/13</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/13</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John H. Eppler, MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/13/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John H. Eppler MD</b>				22e. ADDRESS <b>WMH</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/15/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

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BRITISH MEDICAL HOSPITAL

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1000 BALTIMORE ROAD

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BALTIMORE, MD.

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HENRY W. JONES & SONS CO.

4000 York Road, Baltimore, Md. 21212

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TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Thomas LeCompte</i>		2a. DATE OF DEATH MONTH <i>10</i> DAY <i>5</i> YEAR <i>80</i>		2b. HOUR <i>4:17 PM</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>1</i> - DAY <i>29</i> - YEAR <i>1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greater Pennsylvania Ave. Nursing Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>none</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Md.</i>		13b. COUNTY <i>DOR</i>		13c. CITY OR TOWN <i>Cambridge</i>	
14. FATHER'S NAME FIRST <i>Thomas</i> MIDDLE <i>LeCompte</i> LAST <i>LeCompte</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Jeannette</i> MIDDLE <i>Caroll</i> LAST <i>Caroll</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Balto 21225</i> <i>Julia LeCompte 3520 Sixth St.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Par Kinsonism</i> <i>3320</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Brain Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alcohol Retardation</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>5-25, 1977</i> to <i>10-5, 1980</i> , that (I) (we) lost saw the deceased alive on <i>10-5, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R.O. Crostey</i>		DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.O. CROSTHEY MD</i>		22e. ADDRESS <i>1235 E. Monument Street</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10/7/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview Mem Pk</i>	
24. FUNERAL DIRECTOR NAME <i>George J. Gonce</i>		ADDRESS <i>Balto 21225</i> <i>4001 Ritchie Hgwy.</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 10 1980</i>	
25b. REGISTRAR'S SIGNATURE <i>R. J. McCreedy</i>					

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Zollie Lee</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Oct 10 31 80</b>			2b. HOUR <b>9:21</b> M			
3. SEX <b>male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 11 110</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING HRS) <b>lineup</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. STREET ADDRESS <b>2510 W. Pratt St.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Golden Lee</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Job Moore</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>251-26-2981</b>		17. INFORMANT ADDRESS <b>Mary L. Lee 2510 W. Pratt St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>stroke</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hepatic failure</b> 5728 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b> <b>Weeks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Cirrhosis of the liver</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from <b>10-20 19 80</b> to <b>10-31 19 80</b> , that (I) we saw the deceased alive on <b>10-31 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Octavio A Ruiz MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/31/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Octavio A. Ruiz MD</b>			22e. ADDRESS <b>Bon Secours Hosp Fayette and Baltimore St. Balto. MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/5/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. MD</b>		
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H 1101 E. North Ave.</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Larry Hedberg</b>		

MEDICAL CERTIFICATION



*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8025606	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>MYRTLE K LEIDERMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCT. 31 1980</b>			2b. HOUR <b>2:25 P.M.</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 29 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GERIATRIC LEVINDALE HEBREW TER + HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES LADY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HRY CO.</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1800 FAIRBANK RD. 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE KLOTZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JULIA BEIRMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216-05-9836</b>		17. INFORMANT ADDRESS <b>MR. JAMES B. ZIMMERMAN 1800 FAIRBANK RD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHOMA</b> <b>2028</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>RECURRENT CVA</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (this hospital) attended the deceased from <b>OCT. 22</b> , 19 <b>80</b> , to <b>OCT. 31</b> , 19 <b>80</b> , that (we) last saw the deceased alive on <b>OCT. 31</b> , 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.											
22b. SIGNATURE <b>Estrelita O. Kn</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/31/80</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELITA O. KN</b>						22e. ADDRESS <b>LEVINDALE HEBREW GERIATRIC HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>11/3/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>M. Mitchell-Wiedefeld Home 6500 YORK RD.</b>						25. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Theresa McCready</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8025607

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Layla Lee Leitch</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 14 80</i>		2b. HOUR <i>6 35 PM</i>
3. SEX <i>FEMALE</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10 9 80</i>		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>5</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>BALTO</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Dependent</i>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Maryland</i>	13b. COUNTY <i>A. Arundel</i>	13c. CITY OR TOWN <i>Pasadena</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>7870 Shirley Murphy Ct. Apt. 739</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>David Leitch</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Wenker</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Mary Leitch 7870 Shirley Murphy Ct. Apt. 739</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe Hyaline membrane disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>prematurity, Lt. pneumothorax, renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>possible intracranial hemorrhage &amp; Cardiorespiratory arrest</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/9</i> 19 <i>80</i> , to <i>10/14</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10/14</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>L. D. Lee</i>				22c. DATE SIGNED <i>10/15/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>IM DENK LEE</i>				22e. ADDRESS <i>Mercy Hospital</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Oct. 16, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Pr</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Dorsey Howard Md.</i>					
24. FUNERAL DIRECTOR <i>McCully Funeral Home Mt. &amp; Tuck Neck Rds. Pasadena, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 17 1980</i>	
				25b. REGISTRAR'S SIGNATURE <i>Ricky H. H. H.</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



100 7 1 1950

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25608

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL LEITH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10/27/80</b>			2b. HOUR 7:30 a M					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 26, 1980</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>12hrs</b>		IF UNDER 1 YEAR IF UNDER 74 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Infant</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Frederick</b> 13c. CITY OR TOWN <b>Frederick</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>7417 Betsy Ross Drive, Frederick, Maryland</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Duane Lee Baker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vickie Sue Leith</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Duane Lee Baker, 7417 Betsy Ross</b>						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiovascular collapse**

DUE TO, OR AS A CONSEQUENCE OF

(b) **SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **RESPIRATORY DISTRESS SYNDROME**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**15 min.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

**PREMATURITY**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> , 19 <b>80</b> , to <b>10/27</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/27</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Andrea Zuckerman</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/27/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREA ZUCKERMAN</b>				22e. ADDRESS <b>THE JOHN HOPKINS HOSPITAL, BALTIMORE MD.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 30, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Church Brethren Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harmony Frederick Md.</b>	
24. FUNERAL HOME <b>Smith, Hadeley, Keeney &amp; Basford</b>				25. DATE RECEIVED BY REGISTRAR <b>NOV 3 1980</b>			
106 East Church Street, Frederick, Maryland							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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10-11



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

8 0 2 5 6 0 9  
REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA ELIZABETH LENNING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCT. 20 1980</b>			2b. HOUR M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 2 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>814 S. EATON ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. STREET ADDRESS <b>814 S. EATON ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DANIEL WURST</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215 48 9282</b>		17. INFORMANT ADDRESS <b>JOHN LENNING 814 S. EATON ST.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerosis Heart Disease</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Unmyelized Arterio Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 years</b> <b>10 years</b>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1977</b> , 19____, to <b>1980</b> , 19____, that (I) (we) lost saw the deceased alive on <b>OCT. 19, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>A. B. Paulino</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/24/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. B. PAULINO</b>				22e. ADDRESS <b>5410 Medical Arts Bldg, Balt. Md. 21207</b>			

23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>10/24/1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LION EVANG. LUTH. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>HOFFMANN FUNERAL HOME 3218 HUDSON ST.</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6000 2 6

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

1000 2 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 25610

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST David	MIDDLE A.	LAST Leopold	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
							October 29 80		10:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 5 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.				
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) 609 E. 37th Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stereotyper		12b. KIND OF BUSINESS OR INDUSTRY News Paper		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 609 E. 37th St.		
14. FATHER'S NAME FIRST MIDDLE LAST Leopold		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-03-7846		17. INFORMANT Edward C. Long		ADDRESS Balto., Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Severe atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia started July 1980										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6-18-80, 1980, to 10-6, 1980, that (I) (we) lost saw the deceased alive on 10-6, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Joseph W. Zebley III M.D.		DEGREE		22c. DATE SIGNED 10-29-80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph W. Zebley III M.D.				
22e. ADDRESS 3809 Greenmount Ave., Balto., Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-1-80		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto., Md.				
24. FUNERAL DIRECTOR NAME H.W. Jenkins & Sons Co., Balto., Md.		ADDRESS 4905 York Rd.		25a. DATE REC'D. BY REGISTRAR NOV 3 1980		25b. REGISTRAR'S SIGNATURE Ricky M. [Signature]				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8025611	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Julia</i>		MIDDLE <i>M.</i>		LAST <i>LeRoux</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>OCT. 9, 1980</i>		2b. HOUR M <i>—</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 5 1890</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>90</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>10</i>		IF UNDER 24 HRS HOURS MIN. <i>—</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTIMORE</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>8 Charles Plaza Apt 603 Balt. Md.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas M. Fitzgerald</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ellen T. O'Connor</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>213-20-1168T</i>		17. INFORMANT ADDRESS <i>APT 603 GERALDINE T. TOLKER 8 CHARLES PLAZA 21201</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MESENTERIC VASCULAR THROMBOSIS</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>—</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>JUNE</i> , 19 <i>75</i> , to <i>PRESENT</i> , 19 <i>—</i> , that (I) (we) last saw the deceased alive on <i>10/9</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Joseph D. Notarangelo, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/9/1980</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH D. NOTARANGELO</i>		22e. ADDRESS <i>301 ST. PAUL PLACE 21202</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>OCT. 13, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LOUDON PK. CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE Md.</i>					
24. FUNERAL DIRECTOR NAME <i>M. T. Wiedefeld</i>		ADDRESS <i>Home 6500 York Rd.</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 15 1980</i>		25b. REGISTRAR'S SIGNATURE <i>—</i>					

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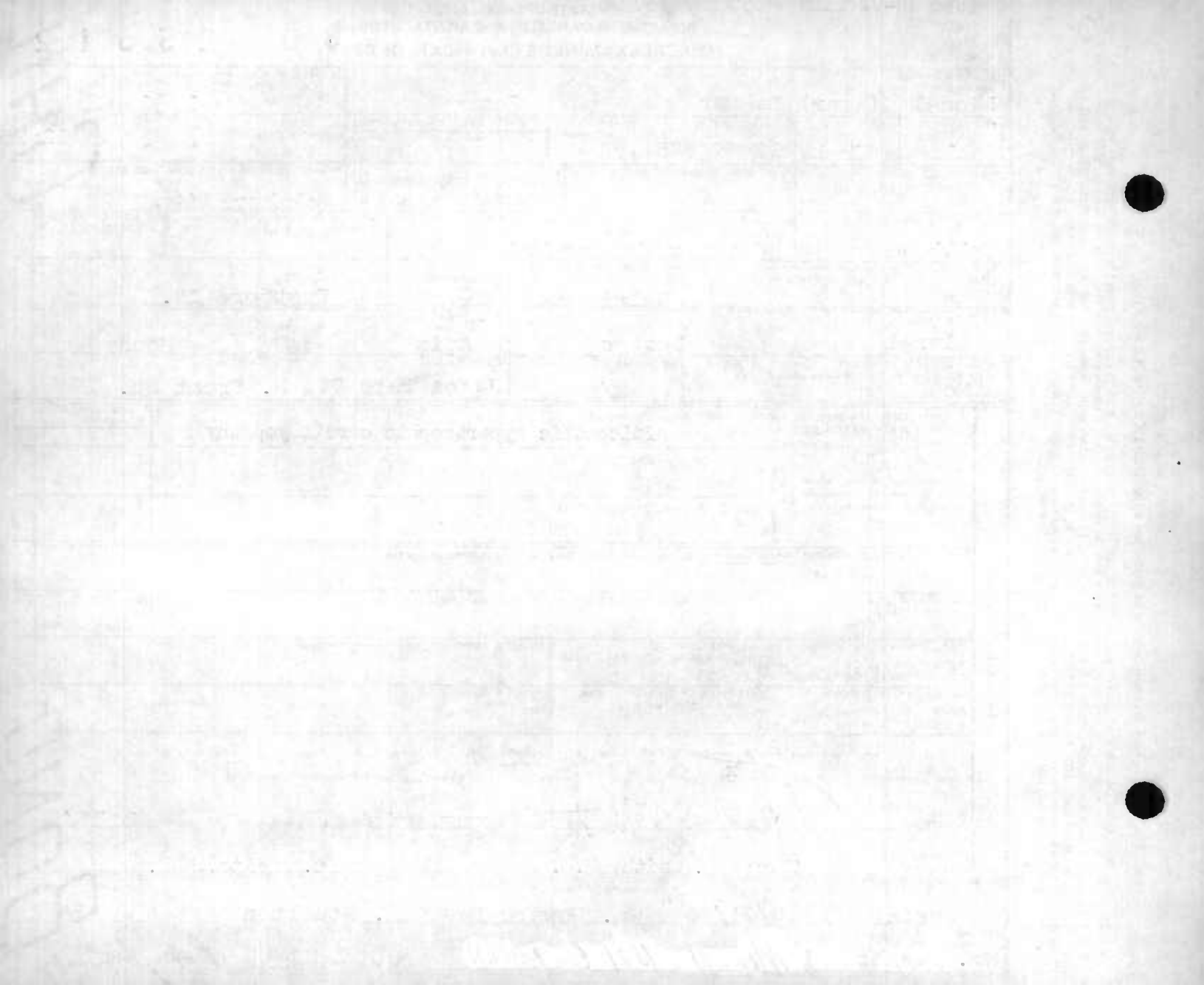
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8 0 2 5 6 1 2

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
		Lionel (Lemar) La Mar						Lester		10		16		19		80		M			
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		Black		12		7		75		4		YRS.		MONTHS		DAYS		10		16	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		MD		7b. CITIZEN OF WHAT COUNTRY?		USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Baltimore City,		MD.							
10. CITY OR TOWN OF DEATH		Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Johns Hopkins Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE		MD		13b. CITY OR TOWN		Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS		85 Eastford Ct.									
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST							
Lionel						Lester		Avis						Moody							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		No		16b. SOCIAL SECURITY NO.		N/A		17. INFORMANT		ADDRESS		James Tate 704 N. Front St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Idiopathic hypertrophic cardiomyopathy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
4254						DUE TO, OR AS A CONSEQUENCE OF															
						(b)		DUE TO, OR AS A CONSEQUENCE OF													
						(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
						P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION		STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				TITLE (SPECIFY)		M. Deputy Chief		DATE SIGNED		10/17/80							
ACTUAL SIGNATURE		Thomas D. Smith																			
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		ADDRESS		111 Penn St. Balto., MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		Burial		23b. DATE		10/21/80		23c. NAME OF CEMETERY OR CREMATORY		Wm. Howard Day Cem.		23d. LOCATION		CITY OR TOWN		Steelton		COUNTY		PA	
24. FUNERAL DIRECTOR		NAME		ADDRESS		Wm. C. March F/H 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR		OCT 20 1980		25b. REGISTRAR'S SIGNATURE		Anthony McCreedy							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 80 25613									
1. DECEASED NAME (TYPE OR PRINT) <b>Marion F. Levering</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 30 19 80</b>										2b. HOUR <b>M</b>																			
3 SEX <b>female</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 7 12 67</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD <b>10 31 19 80</b>		7d. HOUR <b>5:02A</b>																											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD																											
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>719 S Eaton Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sewing Mach. Op.</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>																											
13a. STATE <b>Md.</b>										13b. COUNTY <b>Balto.</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>719 S. Eaton St.</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earl R. Leidich</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence M. Stewart</b>																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										16b. SOCIAL SECURITY NO. <b>217-14-6637</b>										17. INFORMANT ADDRESS																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <input checked="" type="checkbox"/> causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE <i>H. Guard</i>										TITLE (SPECIFY) <b>Assistant</b>										DATE SIGNED <b>10/31/80</b>																			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, MD.</b>										ADDRESS <b>111 Penn Street, Balto., MD 21201</b>																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>										23b. DATE <b>11/1/80</b>										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>										ADDRESS <b>Balto., Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1980</b>										25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 6 1 4 REG. NO.			
1. FOR STATE REGISTRAR							
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Webster S. Levie</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 29, 1980</b>		2b. HOUR <b>11:38 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9/16/01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79 Years</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Unknown Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>City Gov't</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown / Leroy J. Levie</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>213-01-4493</b>		17. INFORMANT ADDRESS <b>Medical Records Department 827 Linden Ave. Maryland General Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 11, 1980</b> to <b>October 29, 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 29, 1980</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <b>Huang-Ta Lin</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>10/30/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Huang-Ta Lin, M.D.</b>				22e. ADDRESS <b>C/O Maryland General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>10/31/80</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1980</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 4 should be filed with the funeral home. If the funeral home is notified at once, it is not necessary to file page 4 with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 21a is marked, or other automatic refrigeration is indicated, the body must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 2 5 6 1 5			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Beatrice F. Levin</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>October 24, 1980</b>		2b. HOUR pm <b>02:26</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCT. 24, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Thye Johns Hopkins Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILIP FINE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA BISOUR</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216-24-2067</b>		17. INFORMANT ADDRESS <b>MRS. TERRY MARCUS</b> <b>2446 FOREST GREEN RD. (21209)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic breast cancer</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 days - onset of cancer</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <b>Oct 1980</b> , 19 <b>80</b> , to <b>Oct 24</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Oct 24</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)							
22b. SIGNATURE <b>LW Martin</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/24/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LW Martin</b>				22e. ADDRESS <b>Johns Hopkins Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-26-80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI TFILOH CONG.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE BALTO. MD</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 28 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Ricky McBrady</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8025616		
1. FOR STATE REGISTRAR			REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH			MONTH DAY YEAR		2b HOUR	
WILLIAM AUSTIN LEWIS						10 29 80			11 30 P M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a IF UNDER 1 YEAR		7b IF UNDER 24 HRS		
MALE		WHITE		09 21 09		71 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.A.				BALTIMORE CITY MD.						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		ST. AGNES HOSPITAL				RADIATOR REPAIR			SELF-EMPLOYED			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b INSIDE CITY LIMITS?		13c STREET ADDRESS				
13a STATE COUNTY						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3103 FREEWAY 21227				
14 FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST						FIRST MIDDLE LAST						
EDWARD LEWIS						SARAH BRADLEY						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17 INFORMANT			ADDRESS			
NO				217-10-5161		INGRID E. LEWIS			3103 FREEWAY, 21227			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Carcinoma of lung with wide spread</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(b) <u>Metastases</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>10-22-80</u> to <u>10-29-80</u> , that (I) (we) lost saw the deceased alone on <u>10-22-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												
22b SIGNATURE						DEGREE			22c DATE SIGNED			
<u>Morton M. Krieger</u>						<u>MD</u>			<u>Oct 31, 1980</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS						
MORTON M. KRIEGER, M.D.						606 HAMMONDS LANE 21225						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION				
BURIAL			11-03-80		CREST LAWN MEM. GAR.			CITY OR TOWN COUNTY STATE				
								MARRIOTTSTVILLE HOWARD MD.				
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
HUBBARD FUNERAL HOME, INC.			4107 WILKENS AVE.			NOV 3 1980		<u>Robert A. Brady</u>				

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CONFIDENTIAL



THE FOLLOWING INFORMATION IS FOR YOUR INFORMATION ONLY. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE UNITED STATES GOVERNMENT AND IS LOANED TO YOU. IT IS TO BE RETURNED TO THE OFFICE OF ORIGIN WHEN NO LONGER NEEDED. IT IS TO BE KEPT IN A SECURE PLACE AND NOT TO BE DISCLOSED TO ANY OTHER PERSON WITHOUT THE AUTHORIZATION OF THE OFFICIAL TO WHOM IT WAS LOANED.

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

25617

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE B. LAST LICATA			2a. DATE OF DEATH MONTH DAY YEAR 10/16/80			2b. HOUR 7:52 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 26 923		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Entertainer	
12b. KIND OF BUSINESS OR INDUSTRY Club							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 21 E. 22nd St.							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-22-2981		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1453 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Squamous Cell CA of Spitz Papule</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>09/25</u> , 19 <u>80</u> , to <u>10/16</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/16/80 6:47</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Maria NC Stack MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/16/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIA STACK, M.D.				22e. ADDRESS UNION MEMORIAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/19/80		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 27 1980	
				25b. REGISTRAR'S SIGNATURE Linton M. ...			

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Florida

Club

01 E. 33rd St.

Radio

NO.



100-2301

NO.

10/19/50

Removal

Radio, No.

Antony Board

OUT 8/19/50

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 2 5 6 1 8  
 REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		BLANCHE		R.		LILLIEN	OCTOBER 28, 1980				5 A <sub>M</sub>
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
FEMALE	WHITE	MONTH DAY YEAR SEPT. 6, 1895	85 YRS.	NEW JERSEY		USA			BALTIMORE CITY		MD.
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE	6210 PARK HTS. AVE. #602		HOUSEWIFE		AT HOME						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
MARYLAND				BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	APT. 602 6210 PARK HTS. AVE. #21215					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		17b. ADDRESS	
HENRY		ANNA		NO		215-22-7962		MRS. GRACE A. DEUMBERG		8203 ARODENE RD. BALTO., MD 21208	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4149		CARDIAC ARREST				CORONARY ARTERIAL DISEASE				21 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 11 SEPT 19 79, to 26 SEPT 19 80, that (I) (do) (do not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22f. ADDRESS					
DR. J. DIXON HILLS		3501 ST. PAUL ST. BALTO., MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		OCT. 29, 1980		HAR SINAI		OWINGS MILLS BALTO. MD					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
SOL LEVINSON & BROS., INC.		6010 REISTERSTOWN RD. BALTO., MD 21215		NOV 5 1980							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 6 1 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sophie W. LimPERT</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>19</b> YEAR <b>80</b>			2b. HOUR <b>2:15 AM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>16</b> YEAR <b>1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>office</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6114 DUNROMING RD</b>			
14. FATHER'S NAME FIRST <b>HARRY</b> MIDDLE <b>W.</b> LAST <b>Wehrheim</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Wilhelmina</b> MIDDLE <b></b> LAST <b>VAN SANT</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>213-18-7167</b>		17. INFORMANT ADDRESS <b>J. Charles Limpert 6114 Dun Roming Rd</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>terminal metastatic Breast Ca (H)</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/16/80</b> , 19 <b></b> , to <b>10/19/80</b> , 19 <b></b> , that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. M. J., M.D.</b>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/19/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD MAUNG-U</b>				22e. ADDRESS <b>5601. Loch Raven Blvd. BALTIMORE.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>OCT. 23, 1980</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cem</b>		23d. LOCATION CITY OR TOWN <b>Cockeysville, MD</b> COUNTY <b>BALTD</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 23 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara A. B...</b>			

06E1 2.3.130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			8025620			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR
John Richard Lindemon			10 16 80						M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS
Male	White	10 13 1892	88 YRS			MONTHS DAYS			HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	John L. Deaton Medical Center			Ship Joiner			Beth-Steel		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS			
Maryland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7004 Morningson Rd.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
William Lindemon			Anna Cullen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT'S ADDRESS			
No			213-07-6520			Sadie E. Lindemon-Box 1164 Ogden Dunes, Portage, Indiana 46368			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA LUNG</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>1 WEEK</u> <u>MOS.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u></u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>10-15</u> 19 <u>80</u> , to <u>10-16</u> 19 <u>80</u> , that (we) lost saw the deceased alive on <u>10-15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>MARC S. POSNER M.D.</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARC S. POSNER</u>			22e. ADDRESS <u>107 E. WEST ST.</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>10/20/1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Duda-Ruck, Inc</u> ADDRESS <u>7922 Wise Ave. Dundalk, Md. 21222</u>			25a. DATE REC'D. BY REGISTRAR <u>OCT 20 1980</u>		25b. REGISTRAR'S SIGNATURE <u>Ricky H. Brady</u>				

BP



3032 Pine Ave. Philadelphia, Pa. 19122  
DeLa-Rue, Inc.  
April 1962

John A. DeLa-Rue, Jr.  
Philadelphia, Pa.  
19122

John A. DeLa-Rue, Jr.  
Philadelphia, Pa.  
19122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at page 1.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 25621	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Lucille Lindsay</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>10/20/80</i>			2b. HOUR <i>1:30 PM</i>		
3. SEX <b>FEMALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 1 16</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Monroe</i>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>510 E. 36th Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Will Garries</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosie Robinson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-12-5009</b>		17. INFORMANT ADDRESS <b>Catherine Paige 611 B Cherrycrest ROAD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxic Encephalopathy</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction &amp; cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>10 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/11</i> , 19 <i>80</i> , to <i>10/20</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>10/20</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>David M. Fishbein</i>						DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>10/20/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID M. FISHBEIN</b>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10/25/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>			
24. FUNERAL DIRECTOR NAME <b>Wm. C. March Funeral Home Inc.</b>						1101 E. North Ave ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Robert A. Kelly</i>	

1862 20

U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WINDY HILLS

SECTION 10





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 2 5 6 2 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Eunice B. LINGAN</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>10 29 80</i>				2b. HOUR <i>745 PM</i>			
3. SEX <i>F</i>		4. RACE <i>CAUC</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 02 01</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. CITY</i> MD.					
10. CITY OR TOWN OF DEATH <i>BALTO.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MERCY HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>MD</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Pikesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>701 Milford Mill Road</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>James P. Barber</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lula Spedden</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-50-0456</i>		17. INFORMANT <i>Miss Lois S. Barber</i> <i>701 Milford Mill Rd., Baltimore, MD 21208</i>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAL ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ANOXIC BRAIN DAMAGE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>RESPIRATORY FAILURE</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3481</i> <i>7 days</i> <i>2 days</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>10/27</i> , 19 <i>80</i> , to <i>10/29</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>10/29</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. Snyder</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>10/29/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SNYDER</i>				22e. ADDRESS <i>MERCY HOSPITAL BALTO MD 21202</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/3/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY <i>Pikesville Baltimore MD</i>					
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, P.A.</i> ADDRESS <i>8728 Liberty Rd., Randallstown, MD 21133</i>				25a. DATE REC'D. BY REGISTRAR <i>OCT 31 1980</i> REGISTRAR'S SIGNATURE <i>Kathy McBrady</i>							



NOV 19 1954

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

FOR STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 5 6 2 3

1. DECEASED NAME (TYPE OR PRINT) <b>DOMINIC JOHN LISANTI</b>			7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>10/16/80</b>			7b. DATE OF DEATH MONTH DAY YEAR <b>10/16/80</b>			7c. HOUR <b>11:45 AM</b>					
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 13, 1920</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>60</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10/16/80</b>			2d. HOUR <b>5:40 PM</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Guard</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>PINKERTON CO.</b>					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>930 Guardian Drive</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Lisanti, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Concetta Fragale</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WAR II</b>				17. INFORMANT ADDRESS <b>Mrs. Frances Aman, Cumberland, Md. Sister</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) <b>Chronic Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <b>K. S. Ahluwalia</b>				TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>10/16/80</b>						
EXAMINER'S NAME (TYPE OR PRINT) <b>K. S. AHLUWALIA</b>				ADDRESS <b>2112 DUNDALK AVE BELT 21222</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Oct. 20, 1980</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1980</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 0 2 5 6 2 4		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE A. LITZ				2a. DATE OF DEATH MONTH DAY YEAR 10 9 80		2b. HOUR 820 A.M.			
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 5/5/02		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -----		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Md.				13b. COUNTY ---		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST ? ? ?				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-05-6191		17. INFORMANT ADDRESS daughter					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> <u>5609</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METABOLIC ACIDOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>INTESTINAL OBSTRUCTION</u> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/9</u> , 19 <u>80</u> , to <u>10/9</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/9</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Enrique Murciano</u>				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Enrique Murciano				22e. ADDRESS UNION MEMORIAL HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPK (IV)) Cremation		23b. DATE 10/9/80		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. Md.			
24. FUNERAL DIRECTOR NAME Paul E. Chenoweth				3617 Chestnut Ave.		25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE <u>Barbara K. Brady</u>	

1-20-25 8

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1-20-25 8

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 25625	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Esther M. Locks										2b. DATE KNOWN OF DEATH ESTIMATED 10 19 80	
3. SEX Female 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR 5 23 09 72 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. 7. CITIZEN OF WHAT COUNTRY? U.S. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD										2c. DATE PRONOUNCED DEAD 10 19 80 2d. HOUR 6:00 p.m.	
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1403 N. Central Avenue										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife 12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD 13b. COUNTY Balto. 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1403 Central Ave.											
14. FATHER'S NAME FIRST MIDDLE LAST Augusta H. CRAWLEY 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HARRIS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 220-09-9515A 17. INFORMANT ADDRESS Edna V. Banks 1403 N. Central Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margaret Brecknall M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-21-80											
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 10/23/80 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE A.A. County Co. MD.											
24. FUNERAL DIRECTOR NAME Locks Funeral Home ADDRESS 1304 N. Central Ave. 25a. DATE REC'D. BY REGISTRAR OCT 22 1980 25b. REGISTRAR'S SIGNATURE R. J. [Signature]											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8025626		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES. LOGAN.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>October 19 1980</b>		2b. HOUR <b>10:15 PM</b>	
3 SEX <b>MALE</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 05 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore city</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>				13b. COUNTY		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b>				16b. SOCIAL SECURITY NO. <b>246-17-3635</b>		17. INFORMANT ADDRESS <b>Chauffeur</b> <b>415 ROBERT STREET.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>aspiration pneumonia.</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>9/9/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>right post. pericardial lesion.</b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/6/80</b> to <b>10/7/80</b> , that (I) (we) last saw the deceased alive on <b>10/5/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Lawrence Agius</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/7/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE AGIUS</b>				22e. ADDRESS <b>University of Maryland Hospital.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>10/9/80</b>		23c. NAME OF CEMETERY OR CREMATORY <b>10/10/</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25. DATE RECD. BY REGISTRAR <b>OCT 20 1980</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



Georgia

Chastain

1974

248-17-2002

Link

10/18/80

XXXX

Removal

Excess, No.

Transfer Board

OCT 20 1980

*Handwritten signature*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 6 2 7

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Charles PETER LOHRAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-19-80</b>		2b. HOUR <b>9 A M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>03-06-03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (TYPE OR PRINT) <b>HUNGARY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. BALTIMORE CITY OR COUNTY OF DEATH <b>City, Balto</b> MD.		
9. CITY OR TOWN OF DEATH <b>BALTIMORE, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>None</b>	
13a. COUNTY <b>MD.</b>		13b. CITY OR TOWN <b>Catonsville</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS <b>P.O. Bx 3235</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>PETER LOHRAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIE A. DUOCZ</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217055765</b>		17. INFORMANT ADDRESS <b>JOSEPHINE LOHRAN 7712 EASTDALE RD. BALTO. MD. 21224</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest.</b> <b>4275</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ <b>Abdominal Aneurysm</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINERS)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from _____ 19____ to _____ 19____, that (two) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) visit the body after death.					
22b. SIGNATURE <b>Michael H. Blume</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/17/80</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael H. Blume</b>		22e. ADDRESS <b>Lutheran Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>10-21-80</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>4430 BELAIR RD. BALTO. MD.</b>
24. FUNERAL DIRECTOR NAME <b>Charles S. Seibert &amp; Son, Inc.</b>		6224 EASTERN AVE. BALTO. 21224, MD.		25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1980</b>	

4

M

10. 11. 1917

Dear Sir,

I have the pleasure to inform you that the same has been forwarded to the proper authorities for their consideration.

Yours faithfully,

[Signature]

2

Very truly yours,

[Signature]

10. 11. 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH				3. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH				3. HOUR			
ARNOLD M. LOHRFINCK		October 9, 1980				8:30 AM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Male	White	Sept. 19, 1903	77 YRS	MONTHS		DAYS		HOURS MIN	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			Baltimore City MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	311 Thornhill Road			Realtor			Real Estate		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		311 Thornhill Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Arnold		Lina		Mueller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
No		217 32 8649		Mrs. Viola A. Lohrfinck		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>acute heart failure Probable MI</u>									2 hours
410 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>HACVD</u>									5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
AT WORK									
22a. I certify that (1) (the hospital) attended the deceased from <u>9-10-80</u> to <u>10-9-80</u> , that (1) (we) last saw the deceased alive on <u>10-6-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Franklin E. Leslie</u>		MD				10-10-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Dr. Franklin E. Leslie, M.D.		3501 St. Paul St., Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Burial		10/13/80		Druid Ridge		Pikesville, Maryland			
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212		OCT 14 1980		<u>Henry W. Jenkins</u>			

Burial 10/10/80 Druid Ridge  
 Henry W. Jackson & Sons Co.  
 4808 York Road Balto., Md. 21212

Dr. Franklin E. Leslie, M.D., 3301 St. Paul St., Balto., Md.

Pikesville, Maryland  
 OCT 14 1980  
*Putney, Mary*

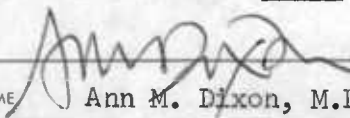
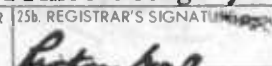
No 217 02 8849 Mrs. Viola A. Lohrnick Same  
 Lohrnick Lohrnick Lina  
 Maryland Baltimore x 311 Thornhill Road  
 Baltimore 311 Thornhill Road  
 Position Real Estate  
 Baltimore City  
 White  
 U.S.A.  
 x  
 1915 10 19 1915 77  
 M. JOHNNIE  
 October 21, 1920

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 5 6 2 9

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 25629									
1. DECEASED NAME (TYPE OR PRINT) <b>ELEANOR</b>					2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>10 4 19 80</b>					2b. HOUR M HOUR P M <b>2:45 p m</b>																			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-12-1898</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>82</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		IF UNDER 24 HRS. <b>0 0 0 0</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>10 4 19 80</b>																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>																	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Consumer Marketing Agent</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>University</b>																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D. C.</b>					13b. COUNTY <b>Wash.</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>3133 Conn. Ave., N. W.</b>														
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aleigh Young</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Heller Molm</b>					16. SOCIAL SECURITY NO. <b>499-38-3873</b>					17. INFORMANT <b>Judy Mc Caffrey</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>					16b. SOCIAL SECURITY NO. <b>499-38-3873</b>					17. INFORMANT <b>Judy Mc Caffrey</b>					ADDRESS <b>Wash., D. C. 888 - 17th St., N. W.</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>8121 Transection of aorta</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:50xx 10-4-1980</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Passenger in auto/truck collision.</b>																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>					21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 108 &amp; Sundown Rd. Montgomery Md.</b>																			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE 					TITLE (SPECIFY) <b>Assistant</b>					DATE SIGNED <b>10-5-80</b>																			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>					ADDRESS <b>111 Penn St.</b>																								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>					23b. DATE <b>10-17-80</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Prince Georges, Md.</b>														
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>										25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1980</b>										25b. REGISTRAR'S SIGNATURE 									
5130 Wisconsin Ave, N. W., Wash., D. C.																													



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |              |   |  | 8 0 2 5 6 3 0<br>REG. NO.  |  |  |   |                                |
|--|--------------|---|--|--|--|--|---|--------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <b>John M. LORING</b>   |              |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 10-4-80   |  |  |   | 2b. HOUR 1130A                 |
| 3 SEX Male   | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 11-25-07  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS   |   | 8. IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD.   |              | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.                 |   |                                |
| 10. CITY OR TOWN OF DEATH BALTIMORE, MD.   |              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITALS |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED  |  | 12b. KIND OF BUSINESS OR INDUSTRY GENERAL MOTORS                         |   |                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD.  |              | 13c. CITY OR TOWN BALTIMORE   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 1004 S. BAYLIS ST. # 21224.                          |   |                                |
| 14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL LORING   |              |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE FLURY.  |  |  |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO   |              | 16b. SOCIAL SECURITY NO. 216-09-1388  |  | 17. INFORMANT ANDREW LORING ;  |  | 1004 S. BAYLIS ST. BALTO., 21224, MD.                                    |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration, Sepsis</u><br>3320<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinsons Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |              |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |              |   |  |  |  |  |   |                                |
| 19a. DATE OF OPERATION   |              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |              | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |                                |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |                                |
| 22. I certify that (I) (this hospital) attended the deceased from 10/1/80, 1980, to 10/4/80, 1980, that (I) (we) lost saw the deceased alive on 10/4/80, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |              |   |  |  |  |  |   |                                |
| 22b. SIGNATURE Hal Cook MD   |              |   |  | DEGREE   |  | 22c. DATE SIGNED 10/4/80   |   |                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAL COOK MD  |              |   |  | 22e. ADDRESS Baltimore City Hospital   |  |  |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |              | 23b. DATE 10-7-80   |  | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE 7401 GERMAN HILL RD. BA. CO., MD |   |                                |
| 24. FUNERAL DIRECTOR NAME Charles J. Giller & Son Inc  |              | 24b. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.   |  | 25. DATE REC'D. BY REGISTRAR OCT 6 1980  |  | 25b. REGISTRAR'S SIGNATURE   |   |                                |

14

JOHN MICHAEL LORING )

BALTIMORE, MD. BALTIMORE CITY HOSPITALS

MD. BALTIMORE 1004 S. SAYLES ST. W. 51234

MICHAEL LORING  
216-02-1388  
ANDREW LORING : BALTO., 51234, MD.  
CATHERINE FRANKY,  
1004 S. SAYLES ST.

10-7-80  
BALTO., 51234, MD.  
001 6 250  
BALTO., 51234, MD.  
10-7-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 0 2 5 6 3 1<br>REG. NO.   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy J Love   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 16, 1980  |  | 2b. HOUR<br>9:35a M   |   |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10/5/1921  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk/Cashier   |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Toytown, USA   |  |  |  |  |  |   |   |
| 13a. STATE<br>Md.   |  |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |   |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET ADDRESS<br>616 Maude Avenue  |  |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Quincy Adams   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Mabel March   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Unknown   |  | 17. INFORMANT<br>ADDRESS<br>Mr. Gary L. Hutson Glen Burnie, Md. 21061<br>510 Norman Ave.   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY: Myocardial infarction due to severe coronary<br>IMMEDIATE CAUSE (a)<br>410-<br>atherosclerosis involving the proximal right coronary<br>Artery,<br>and ostium of left coronary artery   |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Terminal event occurred at the time of a. Coronary Angiogram  |  |  |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 7, 1980, to October 16, 1980, that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on October 16, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |  |  |  |  |  |   |   |
| 22b. SIGNATURE<br>Daniel Lindenstruth, M.D.   |  |  |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/16/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Daniel Lindenstruth, M.D.  |  |  |  | 22e. ADDRESS<br>c/o Maryland General Hospital  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/19/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westonville Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westonville, Barbours Co., W. Va.   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCully Funeral Home  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. Brady   |   |

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October 16, 1960

October 16, 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 80 25632 |  |
|--|--|---|--|---|--|--|--|--|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LESTER</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 17 1980</b>  |  | 2b. HOUR<br><b>6:55 P.M.</b>   |  |          |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 20 99</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>4003 Roland Ave.</b>   |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unkn.</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>717-07-7997</b>  |  | 17. INFORMANT<br>ADDRESS   |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2765</b> IMMEDIATE CAUSE (a) <b>Dehydration</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wk</b> |  |   |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 8</b> , 19 <b>80</b> , to <b>OCT 17</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>OCT 17</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><b>Dr Richard A Lebow</b>  |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10-17-80</b>  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD Lebow</b>  |  |   |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>10/20/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |   |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1980</b>   |  | 25. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |          |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. This certificate should be detached for use as the burial-transit permit. Then please remove the burials pages. Pages 1 and 2 should be filled within 72 hours after death. Pages 3 and 4 should be filled within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requirements of the death certificate are executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 30M 2/80  
(VRA 15, 4)



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 3 3

REG. NO.

| FOR<br>1 - STATE<br>REGISTRAR   |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 0 2 5 6 3 3   |                                      |
|---|---|---|--|---|--------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH   |  | 7a. HOUR  |                                      |
| FIRST MIDDLE LAST<br>LUTHER FRANCIS LOWE  |   | MONTH DAY YEAR<br>OCTOBER 26, 1980  |  | 12:45 PM  |                                      |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  | 7b. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                                      |
| MALE  | WHITE   | MONTH DAY YEAR<br>JAN. 10, 1907   | 73 YRS.  |   |                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |                                      |
| MARION Co., VA.   | U.S.A.  |   | BALTIMORE CITY MD.   |   |                                      |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY    |
| BALTIMORE, MD.  | THE JOHNS HOPKINS HOSPITAL  |   | RETIRED  |   | AUTO MECHANIC.                       |
| 13a. STATE  |   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS                  |
| MD.   | -----   | BALTIMORE   |  |   | # 2120<br>715 N. PATTERSON PARK AVE. |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |                                      |
| CLAUDE LOWE   |   | MARTINA HIGGINS   |  |   |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   | 17. INFORMANT   |  | ADDRESS   |                                      |
| NO  | -----   | L. JEAN LOWE ;  |  | 715 N. PATTERSON PARK AVE<br>BALTIMORE, 21205, MD.  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br><u>4439</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PERIPHERAL VASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |   |                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |   |                                      |
| <u>EMPHYSEMA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</u>  |   |   |  |   |                                      |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                      |
| OCT 23, 1980  | BLADDER OUTLET OBSTRUCTION  |   |  |   |                                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                                      |
|   |   |   |  |   |                                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                      |
|   |   |   |  |   |                                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 23</u> , 19 <u>80</u> , to <u>OCT 25</u> , 19 <u>80</u> , that (I) (we) lost <u>saw the deceased alive on OCT 24</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                            |   |   |  |   |                                      |
| 22b. SIGNATURE  | DEGREE  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED   |   |                                      |
| <u>Leroy M. Nyberg, Jr.</u>   | MD  |   | 10/25/80   |   |                                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS  |   |  |   |                                      |
| LEROY M. NYBERG, JR.  | % JOHNS HOPKINS HOSPITAL, BALT., MD. 21205  |   |  |   |                                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |                                      |
| BURIAL  | 10-28-80  | TRINITY CEM.  | 5500 O'DONNELL ST. BALTO., MD.   |   |                                      |
| 24. FUNERAL DIRECTOR<br>NAME  | 24b. ADDRESS  |   | 24c. DATE REC'D. BY REGISTRAR  | 24d. REGISTRAR  |                                      |
| <u>Charles J. Seiler &amp; Son, Inc.</u>  | 901 S. CONKLING ST.<br>BALTO., 21224, MD.   |   | OCT 27 1980  | <u>Leroy M. Nyberg</u>  |                                      |

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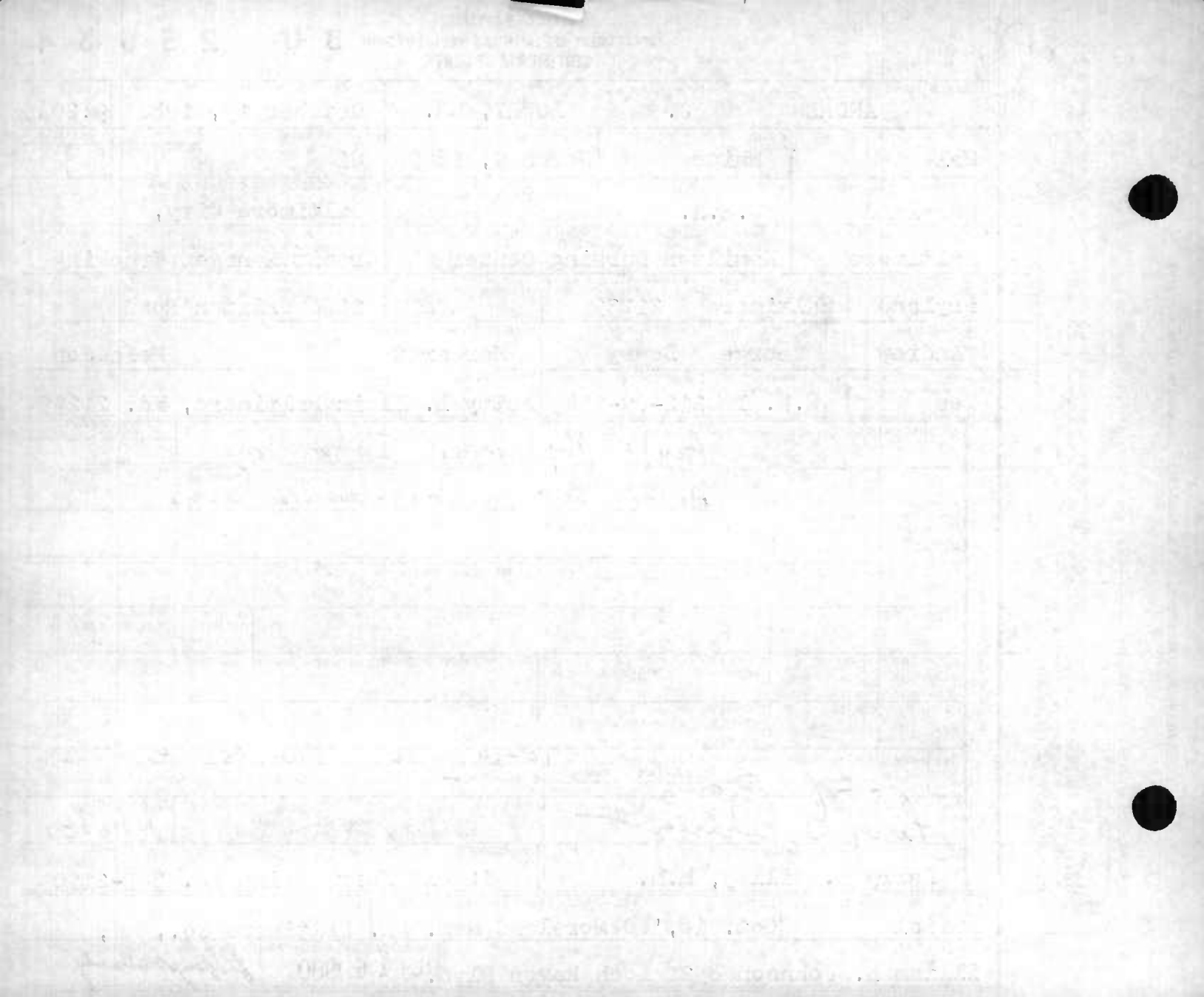
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 3 4

REG. NO.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANDREW J. LOWRY, SR.</b>   |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 15, 1980</b>                            |  | 2b. HOUR<br><b>9:20A<sub>M</sub></b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 9, 1899</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hamilton Nursing Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Credit Manager</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Trucking</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Maryland</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  | 13e. STREET ADDRESS<br><b>1206 Brixton Road</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew George Lowry</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret McFadden</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212-09-1345</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Betty L. Klein Baltimore, Md. 21239</b>         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>410-</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterio Sclerotic Cardio-vascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended to the deceased from <b>10-19</b> , 19 <b>70</b> , to <b>10-15</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>September 19, 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Larry G. Tilley</b>  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>10/16/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Larry G. Tilley, M.D.</b>   |   | 22e. ADDRESS<br><b>1012 Old North Point Rd. 285-2110</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>Oct. 18, '80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>   |   | ADDRESS<br><b>8521 Loch Raven Blvd.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>10/16/1980</b>                             | 25b. REGISTRAR'S SIGNATURE<br><b>Frederick M. Hardy</b>  |





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

25635

REG. NO.

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| PAUL LEON LUCAS   |   |   | 10 13 80   |  |  | 12:02aM  |  |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |
| MALE  | BLACK   | MONTH 8 DAY 15 YEAR 96  | 84 YRS.  |  |  | MONTHS DAYS  |  | HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                   |  |  |  |  |  |
| MARYLAND  | U.S.A.  |   | BALTIMORE MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| BALTIMORE   | VAMC BALTIMORE, MARYLAND 21218  |   |  |  |  |  |  |  |
| 13a. STATE  |   |   | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  |
| MARYLAND  |   |   |  |  |  | BALTIMORE  |  |  |
| 14. FATHER'S NAME   |   |   | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |
| EDGAR LUCAS   |   |   | MARION LUCAS   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |  |  | 17. INFORMANT ADDRESS  |  |  |
| YES   |   |   | WW1  |  |  | 212 05 3379 MARTHA LUCAS 2539 Kirk Avenue  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Squamous cell carcinoma of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOTING THE UNDERLYING CAUSE LAST.  |   |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |   |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JULY 9</u> , 19 <u>80</u> , to <u>OCTOBER 13</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <u>OCTOBER 13</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Prouty MD</u>  |   |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>10/13/80</u>                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>S. PROUTY MD</u>  |   |   |  |  |  | 22e. ADDRESS   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   |   |   |  |  |  | 23b. DATE<br><u>10/17/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Balto. Nat'l Cem.</u> |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore MD</u>   |   |   |  |  |  | 23e. DATE REC'D. BY REGISTRAR  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm. C. March F/H</u>   |   |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 14 1980</u>  |  |  |
| ADDRESS<br><u>1101 E. North Ave.</u>  |   |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Ruby M. Brady</u>   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 8 0 2 5 6 3 6  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>DONALD  |  | MIDDLE<br>C.  |  | LAST<br>LYLE   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED  |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>male  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 - 13 - 23  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>56 YRS                                 |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10 3 80   |  | 2d. HOUR<br>7:26 p.m.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Harbor Place |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MEAT CUTTER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>FOOD   |  |   |  |
| 13a. STATE<br>MD  |  |  |  | 13b. COUNTY<br>CECIL  |  | 13c. CITY OR TOWN<br>RISING SUN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>15 MOUNT ST.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MARTIN L. LYLE  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>HELEN CAMERON  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO                     |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>217-12-3003   |  |  |  | 17. INFORMANT<br>ELIZABETH A. LYLE MD   |  |  |  | ADDRESS<br>RISING SUN MD  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| IMMEDIATE CAUSE (a)<br>4292   |  |  |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |  |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>  |  |  |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |  |  | MEDICAL EXAMINER  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.  |  |  |  | ADDRESS<br>111 Penn St.   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  |  | 23b. DATE<br>10-7-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WEST NOTTINGHAM                        |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>COLORA CECIL MD                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>D.T. FEARD FUNERAL HOME   |  |  |  | ADDRESS<br>RISING SUN MD  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 9 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Rickey McCready                                       |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 6 3 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |   |  |  |
|--|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Grace L. Maas</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>October</b> DAY <b>1</b> YEAR <b>1980</b> |   |  | 2b. HOUR <b>7</b> MIN <b>PM</b>   |   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>Dec</b> DAY <b>21</b> YEAR <b>1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS OAYS<br>IF UNDER 74 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD                               |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green Nursing Home</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-----   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |  |   |   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>400 E. Joppa Road</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Charles R.</b> MIDDLE <b>Horney</b> LAST   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rebecca</b> MIDDLE <b>Ewing</b> LAST   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>212-01-6762</b>  |  | 17. INFORMANT<br>ADDRESS <b>Baltimore, Md.</b><br><b>Charles Horney 4410 Darleigh Rd. 21236</b> |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4409</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug 16</b> 19 <b>80</b> to <b>Aug 16</b> 19 <b>80</b> that (I) (we) last saw the deceased alive on <b>Aug 16</b> 19 <b>80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)       |  |   |   |   |  |   |   |  |  |
| 22a. SIGNATURE<br><b>William Helfrich, M.D.</b>  |  |   |   |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>2 Oct 80</b>  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |   |   |  | 22e. ADDRESS<br><b>5006 Roland Avenue Baltimore, Maryland</b>                                   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>Oct 4, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Dippel Funeral Homes, Inc. 7110 Belair Rd.</b>  |  |   |   |   |  | ADDRESS <b>Balto., Md. 21206</b>  |   | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 2 1980</b>  |  |
| 26. REGISTRAR'S SIGNATURE<br><b>Anthony Helfrich</b>   |  |   |   |   |  |   |   |  |  |

October 1, 1950

Grace L. Case

87

Dec 21, 1952

Miss

Female

Baltimore City,

X

.....

Maryland

Housewife

Old Green Meeting Home

Baltimore

400 E. Johns Road

X

Lawson

Baltimore

Maryland

Rebecca Smith

Charles A. Horney

Baltimore, Md.

Charles Horney 4400 Larkfield Rd. 3038

3-5-01-0102

no

5000 Lark Avenue Baltimore, Maryland

William L. Smith, Jr.

Baltimore, Maryland

Oct 1, 1950

Female

Oct 1, 1950

Special Agent, No. 740



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 6 3 8  
CERTIFICATE OF DEATH

|  |   |   |   |
|--|---|---|---|
| 1. FOR<br>STATE<br>REGISTRAR   |   | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH   |   |
| FIRST MIDDLE LAST<br>Mary Lillian Mabus  |   | MONTH DAY YEAR<br>October 29, 1980  |   |
| 3 SEX  |   | 2b. HOUR  |   |
| Female   |   | 1001 M  |   |
| 4 RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |
| Caucasian  | MONTH DAY YEAR<br>April 20, 1915  | 65 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| Washington, DC   | USA   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |
|  |   | Baltimore MD.   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |
| Baltimore  | 1083 Wilmington Street  | Housewife   |   |
| 12b. KIND OF BUSINESS OR INDUSTRY  |   | 12c. OWN HOME   |   |
| Own home   |   |   |   |
| 13a. STATE   |   | 13b. COUNTY   | 13c. CITY OR TOWN   |
| MD   | AA  | Glen Burnie   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |
| John Hibbert   |   | Mary Kenny  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.  |   |
| No   |   | 212-28-0212   |   |
| 17. INFORMANT  |   | ADDRESS   |   |
| John George E. Mabus, Same as 13   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bone Marrow Failure</u><br>2030<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Multiple Myeloma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 mo.<br>8 1/2 YRS.   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
|  |   |   |   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   |
|  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/7</u> 19 <u>80</u> , to <u>10/29</u> 19 <u>80</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>10/27</u> 19 <u>80</u> , and that in (my <input checked="" type="checkbox"/> four) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did (did not) view the body after death. |   |   |   |
| 22b. SIGNATURE<br><u>Wm. C. Waterfield</u>   |   | 22c. DATE SIGNED<br>10/29/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wm. C. WATERFIELD   |   | 22e. ADDRESS<br>ST AGNES HOSP<br>900 CATON AVE BALT 21229   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |   | 23b. DATE<br>Nov. 1, 1980   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem..  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>James S. Kirkley, Glen Burnie, MD  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1980  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



100% COTTON T-SHIRT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at or

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (FIRST, MIDDLE, LAST)

F. Chase MacCubbins  
MACCUBBINS B B LINPA2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
10 14 80 5<sup>12</sup> PM

3 SEX

MALE

4. RACE

white

5. DATE OF BIRTH

MONTH DAY YEAR  
10 10 80

6. AGE (IN YEARS LAST BIRTHDAY)

3 days

IF UNDER 1 YEAR

MONTHS DAYS  
— 3

IF UNDER 24 HRS

HOURS MIN.  
— —

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Carroll County

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

BALTIMORE CITY HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

CARROLL

13c. CITY OR TOWN

WESTMINSTER

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

823 Chapel Rd.

14. FATHER'S NAME

FIRST MIDDLE LAST  
ROBERT E. MacCubbin

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Linda Anne NOLL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT

Robert E. MacCubbin

ADDRESS

- 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiac arrest

7701

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) MECONIUM aspiration

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/10, 1980, to 10/14, 1980, that (I) (we) lost saw the deceased alive on 10/14 (5<sup>12</sup> PM) 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Miguel Martinez

DEGREE

MD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

10/14/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MIGUEL MARTINEZ

22e. ADDRESS

6000 East Pratt Street Balt.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

23b. DATE

10-15-80

23c. NAME OF CEMETERY OR CREMATORY

WESTVIEW

23d. LOCATION

CITY OR TOWN COUNTY STATE  
BALTIMORE County MD

24. FUNERAL DIRECTOR

Name Thomas J. Zoltowicz

ADDRESS

254 - E. MAIN WESTMINSTER MD

25a. DATE REC'D. BY REGISTRAR

OCT 22 1980

25b. REGISTRAR'S SIGNATURE

History MacCubbin

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

(1)



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 6 4 0

REG. NO.

|  |  |   |   |  |  |  |   |  |  |
|--|--|---|---|--|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Dolly MACK   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>10 23 80                        |  |  | 2b HOUR<br>456 PM  |   |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Black   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>02 12 43  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>37   |   | 7a IF UNDER 1 YEAR<br>MONTHS DAYS<br>7b IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balt City MD  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balt   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Md. Hosp |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Counter girl  |   | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |  |  |  |   |  |  |
| 13a STATE<br>Maryland  |  | 13b COUNTY  |   | 13c CITY OR TOWN<br>Baltimore  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CLARENCE Thompson  |  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amy Johnson |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b SOCIAL SECURITY NO.   |   | 17 INFORMANT ADDRESS<br>1202 Riggs Ave   |  |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) gastro intestinal hemorrhage<br>5715<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) esophageal varices<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) cirrhosis                                 |  |   |   |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 hours<br>6 months<br>1 yr   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |  |   |  |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from June 19 80, to Oct 23 19 80, that (I) (we) last saw the deceased alive on Oct 23 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |   |  |  |
| 22b SIGNATURE<br>Dorothy A. Snow M.D.  |  |   | DEGREE<br>M.D.  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c DATE SIGNED<br>10/23/80  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dorothy A. Snow  |  |   | 22e ADDRESS<br>22 S. Greene St Balt                                   |  |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b DATE<br>10/29/80  |  | 23c NAME OF CEMETERY OR CREMATORY<br>MCALVARY                |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND |  |  |
| 24 FUNERAL DIRECTOR<br>Wm. C. Brown COMM.F.H.  |  |   | ADDRESS<br>1206 09W North Ave   |  |  | 25a DATE REC'D. BY REGISTRAR<br>OCT 29 1980  |   | 25b REGISTRAR'S SIGNATURE<br>Fitzgerald  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |  |  |   |   |   |                     |   |
|--|------------------|--|--|---|---|---|---------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Irene E. Mackert  |                  |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br>10 30 1980          |   |   | 2b. HOUR<br>AM  |                     |   |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 2, 1902   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>78 YRS.                  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 8. IF UNDER 24 HRS.   | 9. DATE<br>PRONOUNCED<br>DEAD<br>10 31 1980   | 10. HOUR<br>2:34 PM |   |
| 11. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland   |                  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 13. MARRIED: <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 14. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                      |                     |   |
| 15. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2806 Orleans st. |  |   |   | 17. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Clerk                        |                     | 18. KIND OF BUSINESS<br>OR INDUSTRY<br>Insurance Co.                      |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>19a. STATE<br>Maryland   |                  | 19b. COUNTY<br>-   |  | 19c. CITY OR TOWN<br>Baltimore  |   | 19d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                     | 19e. STREET ADDRESS<br>2806 Orleans St.,                                  |
| 20. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Mackert, Sr.  |                  |  |  | 21. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine Glock  |   |   |                     |   |
| 22. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -   |                  | 23. SOCIAL SECURITY NO.<br>212-07-0548   |  | 24. INFORMANT<br>3425 Woodstock Ave.<br>William Mackert, nephew, 21213  |   |   |                     |   |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                  |  |  |   |   |   |                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                           |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (in).   |                  |  |  |   |   |   |                     |   |
| 26a. DATE OF OPERATION   |                  |  | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |   |   |   |                     | 26c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 27a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  | 27b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |   | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |                     |   |
| 27d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                  |  | 27e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, FARM, ETC.) |   | 27f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |                     |   |
| 28. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |   |   |                     |   |
| ACTUAL<br>SIGNATURE<br>Thomas D. Smith   |                  |  | TITLE (SPECIFY)<br>Deputy Chief                                |   |   |   |                     | DATE<br>SIGNED 11/1/80  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |                  |  | ADDRESS<br>111 Penn st. Balto., MD.                            |   |   |   |                     |   |
| 29a. BURIAL, CREMATION, REMOVAL<br>(TYPE)  |                  | 29b. DATE<br>11/3/80   |  | 29c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |   | 29d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                                     |                     |   |
| 30. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.   |                  |  |  | ADDRESS<br>3331 Brehms Lane<br>Balto., Md. 21213  |   | 31. DATE REC'D. BY REGISTRAR<br>NOV 5 1980  |                     | 32. REC'D. BY REGISTRAR<br>[Signature]                                    |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |                  |                  |  |  |  |  |   |                |                                 |  |   |  |  |  |  |  |                         |  |  |
|--|--|------------------|------------------|--|--|--|--|---|----------------|---------------------------------|--|---|--|--|--|--|--|-------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                  | FIRST<br>LaTisha |  |  | MIDDLE<br>Mackey                           |  |   | LAST<br>Mackey |                                 |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED  |  |  | <input checked="" type="checkbox"/> MONTH<br><input type="checkbox"/> DAY<br><input type="checkbox"/> YEAR |  |  | 2b. HOUR<br>M           |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black |                  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 23 80  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS. |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS  |                | 8. IF UNDER 24 HRS<br>HOURS MIN |  | 2c. DATE<br>PRONOUNCED<br>DEAD  |  |  | 10 17 1980   |  |  | 2d. HOUR<br>12:20A<br>M |  |  |
| BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>MD   |  |                  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |  |  |  |                         |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hospital |  |  |  |   |                |                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)                                |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY     |  |                         |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD |  |                  |                  | 13b. COUNTY<br>BALTIMORE   |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |                |                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET ADDRESS<br>706 Reedbird Ave. |  |                         |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alphonso Mackey  |  |                  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Carr   |  |  |  |   |                |                                 |  |   |  |  |  |  |  |                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No                                    |  |                  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A   |  |  |  | 17. INFORMANT<br>ADDRESS<br>Mary Carr 706 Reedbird Ave.   |                |                                 |  |   |  |  |  |  |  |                         |  |  |

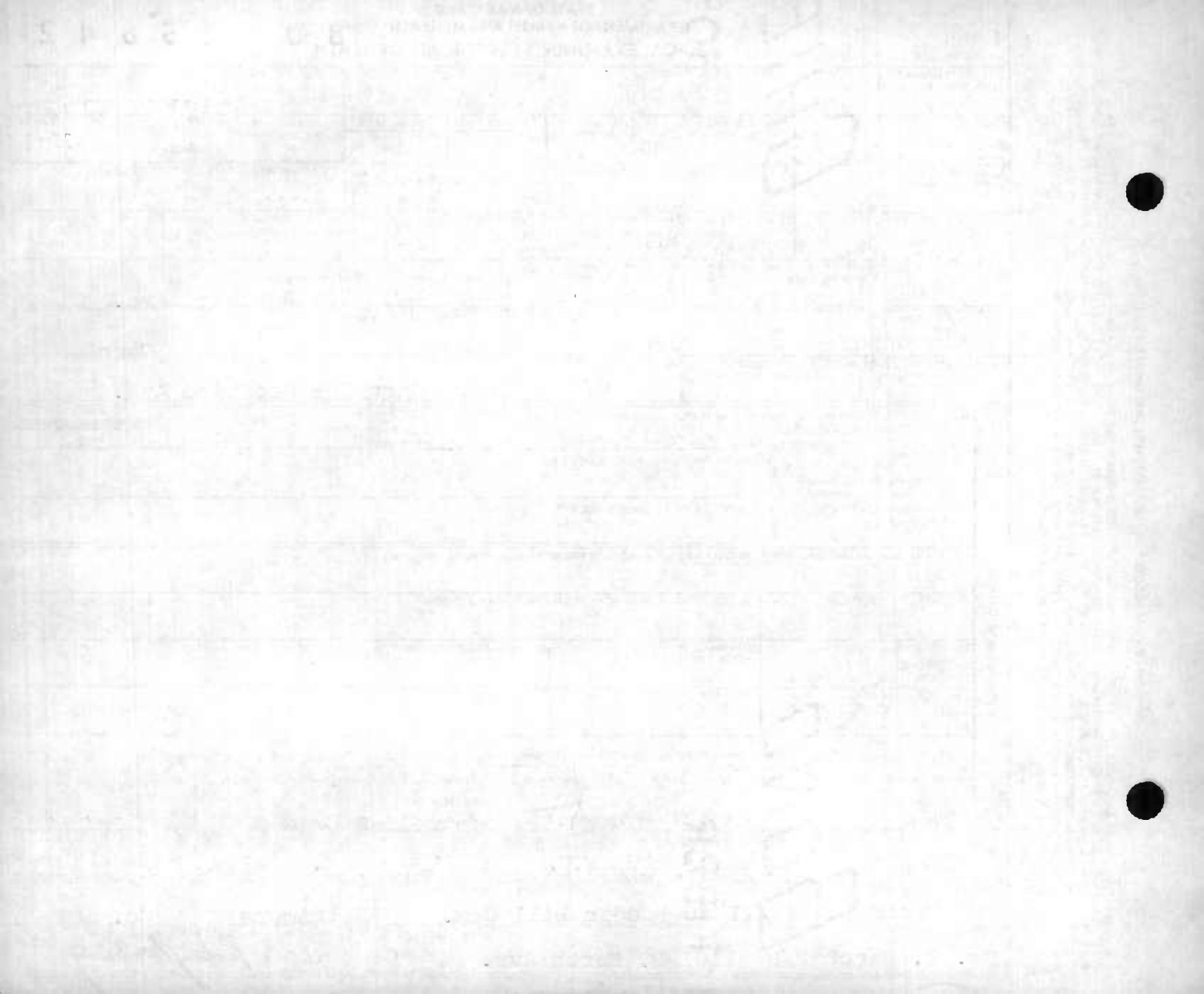
|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u><br>7980<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>TITLE (SPECIFY)<br>M.D. Deputy Chief MEDICAL EXAMINER<br>DATE SIGNED 10/17/80<br>ACTUAL SIGNATURE<br>EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto., MD. |  |  |  |   |  |

|   |  |                       |  |   |  |  |  |
|---|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                      |  | 23b. DATE<br>10/21/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H ADDRESS 1101 E. North Ave. |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1980          |  | 25b. REGISTRAR'S SIGNATURE<br>Ricky McBrady                    |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  | 8 0 2 5 6 4 3                                  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | REG. NO.                                       |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MYRTLE</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>11</b> YEAR <b>80</b>  |   |  |  |  | 2b. HOUR<br><b>7 40</b> AM                     |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>10</b> YEAR <b>98</b>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>82</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4122 Hamilton Ave. 21206</b>   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b></b> LAST <b>Warehime</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b></b> LAST <b>Hecker</b>  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>219-56-4178</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Hazel Steele 4122 Hamilton Ave.</b>                              |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4151</b> IMMEDIATE CAUSE (a) <b>INTRA ABdominal BLEEDING</b> WALL<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Anticoagulation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pulmonary Emboli</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 days</b><br><b>2 wks</b> |  |   |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>HISTORY OF CONGESTIVE HEART FAILURE</b>  |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>7/30/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Angiogram for Pulmonary Emboli</b>                                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/28</b> , 19 <b>80</b> , to <b>10/11</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>S. Scalia</b>   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>10/11/80</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SCALIA</b>   |  |   |  |   | 22e. ADDRESS<br><b>301 St. Paul St.</b>  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10-15-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                                 |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc. 6415 Belair Rd.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b> |  |  |  |  |  |  |

MEDICAL CERTIFICATION

2002

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 4 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE E MADDOX</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>OCT. 12 1980</b>                            |   | 2b. HOUR<br><b>820 AM</b>                        |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>BLACK</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 2 1888</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b><br>YRS MONTHS DAYS HOURS MIN                        |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>2113 N. BOLTON ST.</b> |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LEGARD MADDOX</b>   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY JANE BOND</b>              |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES</b>                |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-9550</b>   |  | 17 INFORMANT<br>ADDRESS<br><b>JOSEPH MADDOX 2113 N. BOLTON ST.</b>                              |  |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIAC ARRYTHMIA**410-  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **MYOCARDIAL INFARCTION**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

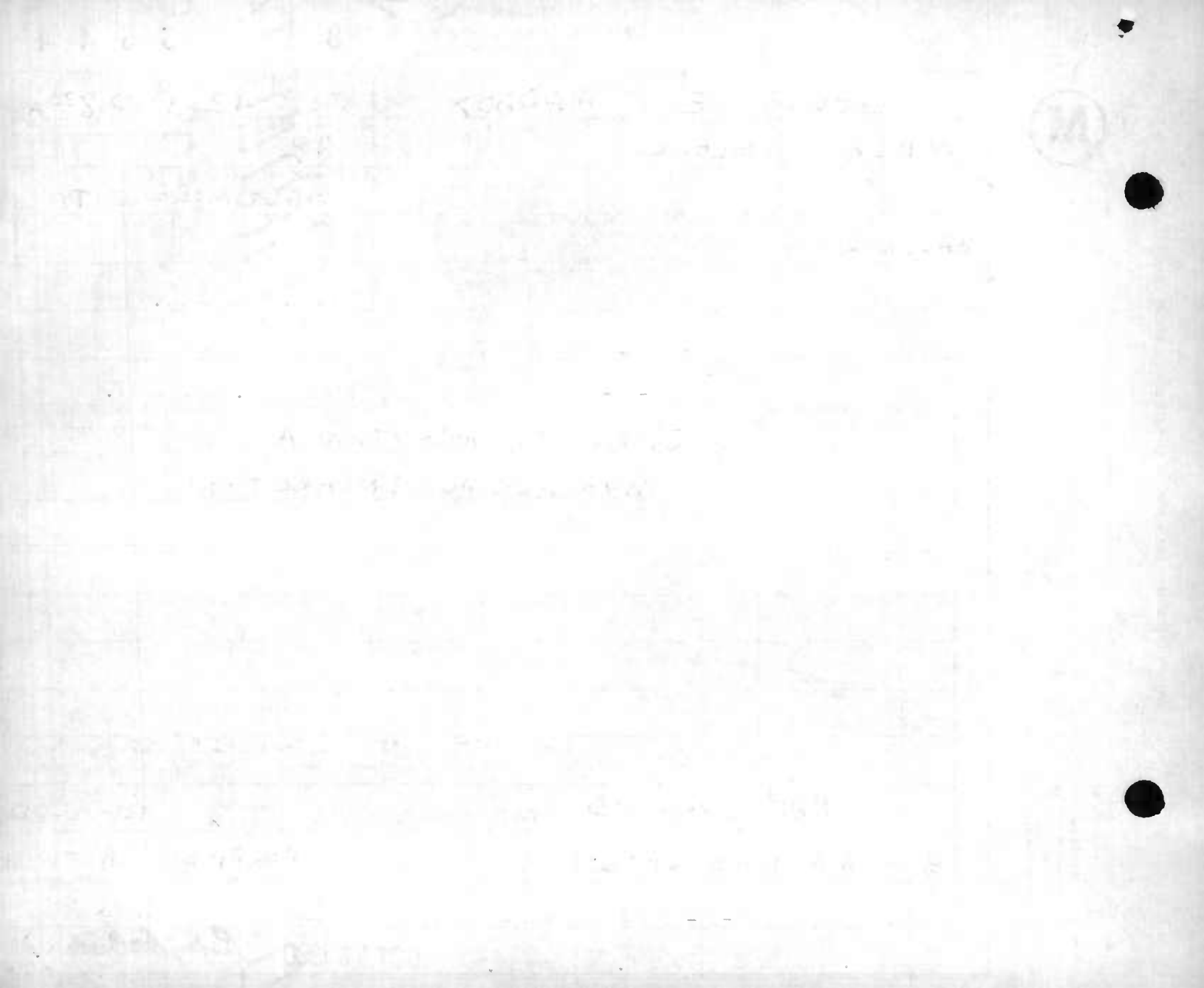
|   |   |  |   |
|---|---|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT. 11TH 1980</b> to <b>OCT. 12TH 1980</b> , that (I) (we) last saw the deceased alive on <b>OCT. 12TH 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |
| 22b. SIGNATURE<br><b>BEN MAGNUS-LAWSON MD</b>   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10-12-80</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BEN MAGNUS-LAWSON MD</b>  |   | 22e. ADDRESS<br><b>PROVIDENT HOSPITAL BALTIMORE</b>                            |   |

|  |                              |  |   |
|--|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                          | 23b. DATE<br><b>10-18-80</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b> |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ELIZABETH L. PHILLIPS 1721 n. monroe st.</b> |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1980</b>        | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. H. H. H.</b>                     |

Page 4 of 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

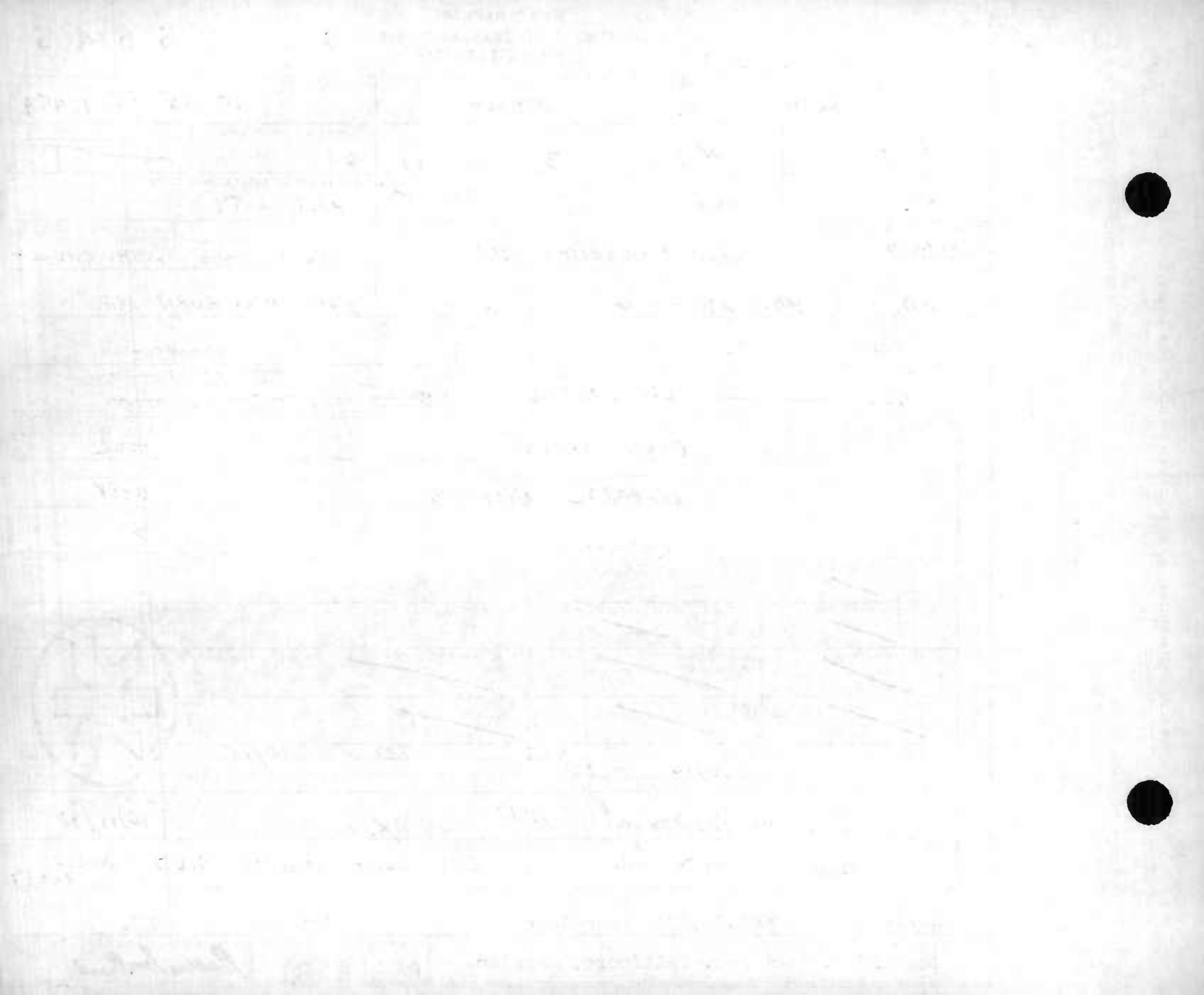
8 0 2 5 6 4 5

1- FOR  
STATE REGISTRAR *Ruth H. Maisch*

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>RUTH H. MAISCH</i>   |  |   | 2a. DATE OF DEATH<br>MONTH <i>10</i> DAY <i>15</i> YEAR <i>80</i><br>2b. HOUR <i>1:45 AM</i> |  |  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>                    | 5. DATE OF BIRTH<br>MONTH <i>3</i> DAY <i>25</i> YEAR <i>19</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>61</i><br># UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i><br># UNDER 24 HRS MONTHS <i>0</i> DAYS <i>0</i> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Md.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALT. CITY</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>GOOD SAMARITAN HOSP.</i>                    |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>SELY. Grace</i>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>LUTH. CHURCH</i>   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MD.</i> 13b. COUNTY <i>BALT CITY</i> 13c. CITY OR TOWN <i>Baltimore</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>5411 HILL BURN AVE.</i>    |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <i>Henry</i> MIDDLE <i>J.</i> LAST <i>Maisch Jr.</i>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Lula</i> MIDDLE <i>Schaeffer</i> LAST <i>Schaeffer</i>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO.</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>220-07-7844</i>  |  | 17. INFORMANT<br><i>XXXXXX Mrs. Evelyn M. Barnes</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>RESP. ARREST</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>CEREBRAL NECROSIS</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>UNKNOWN</i>   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>HOURLY</i><br><i>WEEK</i><br><i>?</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><i>10-7-80</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>10-7-80</i>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>10-7-80</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>10-7-80</i>   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>10-7-80</i>  |  | 21f. LOCATION<br>STREET <i>10-7-80</i> CITY OR TOWN <i>10-7-80</i> COUNTY <i>10-7-80</i> STATE <i>10-7-80</i>                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-7-80</i> to <i>10-15-80</i> , that (I) (we) lost<br>saw the deceased alive on <i>10-14-80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Dan H. McDougal</i> DEGREE <i>MD</i>  |  |   |  | 22c. DATE SIGNED<br><i>10/15/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DAN H. MCDUGAL</i>   |  |   |  | 22e. ADDRESS<br><i>5601 LOTH RAVEN BLVD. BALTO 21239</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>Oct. 18, 1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn</i>  |  |
| 23d. LOCATION<br>CITY OR TOWN <i>Baltimore</i> COUNTY <i>Md.</i> STATE <i>Md.</i>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Leonard J. Ruck Inc. Baltimore, Maryland</i> ADDRESS <i>Baltimore, Maryland</i>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <i>OCT 16 1980</i> 25b. REGISTRAR'S SIGNATURE <i>Robert H. H. H.</i>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 70 25646<br>REG. NO.  |  |   |  |  |  |
|---|--|---|--|---|--|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) <b>PAULINE</b>  |  |   |  | FIRST <b>PAULINE</b> MIDDLE <b>MAKARSKY</b> LAST <b>MAKARSKY</b>  |  |   |  | 2a DATE OF DEATH MONTH <b>10</b> DAY <b>27</b> YEAR <b>80</b>   |  |   |  | 2b HOUR <b>5:00 P.M.</b>                     |  |
| 3 SEX <b>F FEMALE</b>   |  | 4 RACE <b>C WHITE</b>   |  | 5 DATE OF BIRTH MONTH <b>5</b> DAY <b>15</b> YEAR <b>15</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS  |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS HOURS <b></b> MIN <b></b> |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND S.A.</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S. U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY A.A.Co.</b> MD.                       |  |   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Brooklyn Pk. Md.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HAMMONS LANE NURSIN CENTER.</b> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE.</b>              |  | 12b KIND OF BUSINESS OR INDUSTRY <b>ATHOME</b>  |  |   |  |  |  |
| 13a STATE <b>MARYLAND</b>   |  | 13b COUNTY <b>BALTIMORE</b>   |  | 13c CITY OR TOWN <b>BALTIMORE</b>   |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS <b>1350 E. FORT AVE. 21230.</b>  |  |   |  |  |  |
| 14 FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b></b> LAST <b></b>   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>UNKNOWN</b> LAST <b>Sawicki</b>   |  |   |  |   |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b SOCIAL SECURITY NO. <b>216 05 7428</b>  |  | 17 INFORMANT <b>PAULETTE</b> ADDRESS <b>MAKARSKY</b>  |  |   |  | ADDRESS <b>DAUGHTER 8, CHARLE PL NORTHOWER, APT 902 BALTO. 21201.</b>   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>   |  |   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| <b>4912</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC BRONCHITIS</b>  |  |   |  |   |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>MITRAL STENOSIS.</b>  |  |   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/10/1980</b> to <b>10/27/1980</b> , that (I) (we) last saw the deceased alive on <b>10/27/1980</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>K. Dharmasena</b>   |  |   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED <b>10/27/80</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. DHARMASENA</b>  |  |   |  | 22e. ADDRESS <b>#8, 16th AVE. BALTIMORE Md 21225.</b>   |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>10/30/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY TRINITY R.O. CEM.</b>  |  | 23d. LOCATION CITY OR TOWN <b>ELKRIDGE</b> COUNTY <b>MARYLAND</b> STATE <b>MARYLAND</b>     |  |   |  |   |  |  |  |
| 24 FUNERAL DIRECTOR NAME <b>DIPPEL FUNERAL HOME 1800 E. LOMBARD ST. 21231</b> ADDRESS <b>BALTIMORE MARYLAND</b>   |  |   |  | DATE REC'D. BY REGISTRAR <b>OCT 29 1980</b>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH: 16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |               |   |  |   |  |
|---|---------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MARY MIDDLE E LAST MALONEY  |               |   | 2a. DATE OF DEATH MONTH 10 DAY 7 YEAR 80 |   | 2b. HOUR 6:30 PM                             |
| 3. SEX Female   | 4. RACE White | 5. DATE OF BIRTH MONTH 1 DAY 15 YEAR 85   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.   |               | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH BALTO   |               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SBGH |  | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED   |               |   |  |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY Housewife   |               |   |  |   |  |
| 13a. STATE MD   |               |   |  |   |  |
| 13b. COUNTY   |               | 13c. CITY OR TOWN BALTO.  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET ADDRESS 1513 FILBERT ST.  |               |   |  |   |  |
| 14. FATHER'S NAME FIRST MICHAEL MIDDLE LAST   |               | 15. MOTHER'S MAIDEN NAME FIRST BESSIE MIDDLE LAST KERWIN  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |               | 16b. SOCIAL SECURITY NO. 179-28-6301  |  | 17. INFORMANT ADDRESS Mary E. Sledgeski 1513 Filbert St. Balto.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST.<br>410- DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MI & CHF<br>DUE TO, OR AS A CONSEQUENCE OF (c) RHEUMATIC VALVE DISEASE<br>1 day                           |               |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |               |   |  |   |  |
| 19a. DATE OF OPERATION  |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |               |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |               | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/7 1980 to 10/7 1980, that (I) (we) lost saw the deceased alive on 10/7 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |               |   |  |   |  |
| 22b. SIGNATURE Steven Rapp  |               | DEGREE  |  | 22c. DATE SIGNED 10/7/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN RAPP   |               | 22e. ADDRESS SBGH   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |               | 23b. DATE Oct. 10, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery   |  |
| 23d. LOCATION City or Town Pittston, County Pennsylvania  |               |   |  |   |  |
| 24. FUNERAL DIRECTOR McCutty Funeral Home 4200 Pennington Ave. Balto. Md.   |               |   |  | 25a. DATE REC'D. BY REGISTRAR OCT 14 1980   |  |
|   |               |   |  | 25b. REGISTRAR'S SIGNATURE  |  |

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



RECEIVED

TO THE DIRECTOR, BUREAU OF LAND MANAGEMENT  
FROM THE [illegible]



TO THE DIRECTOR, BUREAU OF LAND MANAGEMENT  
FROM THE [illegible]

1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                     |  |  |  |   |  |  |   | REG. NO. 25648  |  |
|---|--|---------------------|--|--|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |                     |  |  |  |   |  |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>COLOSSIE MALLORY</b>   |  |                     |  |  |  |   |  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 15 1980</b> |  |
| 3 SEX <b>male</b>   |  | 4 RACE <b>negro</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 5 21 59 YRS</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b>                       |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |   | 2b. HOUR <b>1:10 p</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland Co NC.</b>  |  |                     |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                     |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Apprentice</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b>  |  |                     |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>                              |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS <b>201 E. LAMARQUE AVE</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Samuel Mallory</b>  |  |                     |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Ellen Gray</b> |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>  |  |                     |  | 16b. SOCIAL SECURITY NO. <b>237-24-7888</b>  |  | 17. INFORMANT ADDRESS <b>CORNER DUNSTON 3409 K. WARDEN RD</b>   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Chronic alcoholism</b><br>IMMEDIATE CAUSE (a) <b>303-</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                     |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                     |  |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                     |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                     |  |  |  |   |  |  |   |   |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b> M.D.   |  |                     |  |  |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER               |  |  | DATE SIGNED <b>10-16-80</b>                     |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |                     |  |  |  | ADDRESS <b>111 PennSt.</b>                                      |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>  |  |                     |  | 23b. DATE <b>10/17/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>RUSTIN FAMILY</b>         |  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>WOODBON N.C.</b>   |  |
| 24. FUNERAL DIRECTOR <b>M. Hayes 638 N. Gilman St</b>   |  |                     |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1980</b>                |  |  | 25b. REGISTRAR'S SIGNATURE <b>Rita McCreedy</b> |   |  |

03-21-01

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |  |  | 8 0 2 5 6 4 9                                |  |
|--|--|--|--|--|---|---|--|--|--|--|--|
| FOR<br>STATE<br>REGISTRAR  |  |  |  |  |   |   |  |  |  | REG. NO.                                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nazareno Mangialardi  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 28, 1980  |   |  | 2b. HOUR<br>6:40 AM  |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 11 1894  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                       |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1232 S. Charles St. |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Shop Keeper |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-employed   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br>1232 S. Charles St.             |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Pietro Mangialardi  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Augusta Gerinni  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---         |  | 17 INFORMANT<br>ADDRESS<br>Upton T. Norris 1232 S. Charles St.  |   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u><br><u>1950</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>9th prostate</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 20, 1980</u> to <u>Oct. 28, 1980</u> , that (I) (we) last saw the deceased alive on <u>Oct. 27, 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Richard Lozada</u>  |  |  |  |  | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>10/28/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICARDO LOZADA  |  |  |  |  | 22e. ADDRESS<br>1228 S. Charles St. Balto. Md. 21230  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>10/28/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Hubbard Funeral Home, 4107 Wilkens Ave. 21229   |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1980  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia McCreedy</u> |  |  |  |  |

100-200000

8

100-200000



[Faint, mostly illegible text covering the main body of the page, possibly a form or report.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 22 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |                     |  | 8 0 2 5 6 5 0   |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|---|--|--|--|---|--|---------------------|--|-----------------|-----|------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |  |  |   |  |                     |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH           | DAY | YEAR       | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Paul  |  | A.  |  | Manning  |  |   |  | 10                  |  | 11              | 80  | 6 34 AM    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Male  |  | White   |  | July 21, 1892  |  | 88 YRS.   |  | MONTHS              |  | DAYS            |     | HOURS MIN. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                     |  |                 |     | MD.        |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maryland  |  | USA   |  |  |  | Baltimore City  |  |                     |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Baltimore City  |  | Union Memorial Hospital   |  | Machinist  |  | Beth. Steel   |  |                     |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maryland  |  |   |  | Balto.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 814 Gorsuch Avenue  |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 FATHER'S NAME  |  | 15 MOTHER'S MAIDEN NAME   |  |  |  |   |  |                     |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| FIRST   |  | MIDDLE  |  | LAST   |  | FIRST   |  | MIDDLE              |  | LAST            |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| William   |  |   |  | Manning  |  | Margaret  |  |                     |  | Fitzpatrick     |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT   |  | ADDRESS   |  |                     |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| No  |  | 705 07 2336   |  | Mrs. Margaret A. Manning   |  | Same  |  |                     |  |                 |     |            |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary heart failure. CVA - stroke</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). |  |   |  |  |  |   |  |                     |  |                 |     |            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>Yes</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  |  |  |   |  |                     |  |                 |     |            |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |   |  |                     |  |                 |     |            |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  |  |  |   |  |                     |  |                 |     |            |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/12</u> 19 <u>80</u> to <u>10/11</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/10</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |                     |  |                 |     |            |  |  | 22b. SIGNATURE<br><u>Dwight J. Weglein MD</u><br>DEGREE <u>Resident</u><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><u>10/11/80</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>WEGLEIN</u>   |  |   |  |  |  |   |  |                     |  |                 |     |            |  |  | 22e. ADDRESS<br><u>Union Memorial Hospital</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  |   |  |  |  |   |  |                     |  |                 |     |            |  |  | 23b. DATE<br><u>10/14/80</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Cathedral</u>                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Balto., Md.</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br><u>Henry W. Jenkins &amp; Sons Co.</u>  |  |   |  |  |  |   |  |                     |  |                 |     |            |  |  | 24b. ADDRESS<br><u>4905 York Road Balto., Md. 21212</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 14 1980</u>                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

4000 York Road Baltimore, Md. 21215  
 Henry W. Jenkins & Son Co.  
 1014/80 New Cathedral Baltimore, Md.  
 Mr. Jenkins

Union Memorial Hospital, 120

No 705 07 2386 Mrs. Margaret A. Manning Same

William Manning Margaret Fitzpatrick  
 Maryland Baltimore x 814 Cornwell Avenue

Baltimore City Union Memorial Hospital  
 Maryland USA Baltimore City  
 Male White x July 21, 1882 83

Paul A. Manning



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 8025651         |     |   |          |
|--|--|--|--|--|--|---|--|--|--|-----------------|-----|---|----------|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |  |                 |     |   |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH                                |  | MONTH           | DAY | YEAR  | 2b. HOUR |
| JOYCE  |  | F.   |  | MARCOUS  |  |   |  | 10   |  | 27              | 80  | 8:35 P.M.   |          |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                                  |  | IF UNDER 24 HRS |     |   |          |
| FEMALE   |  | WHITE  |  | 6 10 21  |  | 59  |  | MONTHS   |  | DAYS            |     | HOURS MIN.  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                 |     |   |          |
| Australia  |  | USA Australia  |  |  |  | BALTIMORE CITY  |  |  |  |                 |     | MD.   |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                 |     |   |          |
| Baltimore  |  | SINAI HOSPITAL OF BALTIMORE  |  | Housewife  |  | Home  |  |  |  |                 |     |   |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                              |  |                 |     |   |          |
| MD.  |  | BALTIMORE  |  | COCKEYSVILLE   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 603 J. CRANBROOK                                 |  |                 |     |   |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |                 |     |   |          |
| Daniel   |  | Mary   |  |  |  |   |  |  |  |                 |     |   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                 |     |   |          |
| No   |  | 002-20-4787  |  | John D. Marcous  |  | Burke Va.   |  |  |  |                 |     |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)  |  | 19. IMMEDIATE CAUSE (a)  |  | 20. DUE TO, OR AS A CONSEQUENCE OF   |  | 21. DUE TO, OR AS A CONSEQUENCE OF                                  |  | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                 |     |   |          |
| 1749   |  | METASTATIC BREAST CANCER   |  |  |  |   |  | 10 years   |  |                 |     |   |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                 |  |  |  |  |  |   |  |  |  |                 |     |   |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |                 |     |   |          |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                 |     |   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  |   |  |  |  |                 |     |   |          |
|  |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                 |     |   |          |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |                 |     |   |          |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE           |     |   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | OCT 27   |  | 19 80  |  | , to  |  | OCT 27   |  | 19 80           |     | , that (I) (we) last saw the deceased alive on  |          |
|  |  | OCT 27   |  | 19 80  |  |   |  |  |  |                 |     | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |          |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |                 |     |   |          |
| Mark Himmelheber MD  |  | MD   |  | 10/27/80   |  |   |  |  |  |                 |     |   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |                 |     |   |          |
| MARK HIMMELHEBER MD  |  | SINAI HOSPITAL OF BALTIMORE  |  |  |  |   |  |  |  |                 |     |   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY   |  | STATE           |     |   |          |
| Burial   |  | 10-30-80   |  | Hillcrest Cem.   |  | Annapolis A.A.  |  | MD.  |  |                 |     |   |          |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |                 |     |   |          |
| Robert S. Barranco   |  | NOV 3 1980   |  | [Signature]  |  |   |  |  |  |                 |     |   |          |



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 FOR  
1 - STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 6 5 2

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Joseph A. MARCUS</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 4 80</b> |   |  | 2b. HOUR<br><b>755A</b>   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9- 27-- 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balt. City Hosp.- Burn Unit</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired- Milmark Co.</b>                                       |  |
| 13a. STATE<br><b>Md.</b>  |  |   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Crofton</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jack</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Sasbon</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>055-10-3618</b>  |  | 17. INFORMANT ADDRESS<br><b>Mildred Marcus Same as # 13</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br>8939<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>BT 12% 3rd DEGREE BURNS</b><br>(c) <b>4 HRS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 MIN</b> |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>AMYOTROPHIC LATERAL SCLEROSIS / CARDIOMYOPATHY</b>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3 10 4 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>CLOTHING CAUGHT FIRE @ HOME</b>  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>HOME</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>CROFTON MD</b>  |  |   |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>Oct 4</b> , 19 <b>80</b> , to <b>Oct 4</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Oct 4</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>C. Ye</b>  |  | DEGREE<br><b>MR</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/4/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES J. Ye</b>   |  |   |  | 22e. ADDRESS<br><b>Baltimore City Hosp</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10-7-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakemont Mem. Gardens Davidsonville, Md.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Beall Funeral Home</b><br><b>16,000 Annapolis Rd. Bowie, Md. Vira</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 9 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

Released on Approval By Medical Examiner

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21a marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



No 022-10-3612 Miltred Marcus Same as # 13  
Jack Marcus Julia 2 asson  
Mr. A.A. Crofton 1706 Terrytown Ave.  
Baltimore Baltimore Baltimore  
New York U.S.A.  
Male Caucasian 3-27--17 63  
X

16,000 Annapolis Rd, Bowie, Md. 20713  
Geall Funeral Home  
Burial 10-7-50 Lakmont Mem. Gardens Davidsonville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  |  |  |   |   |  | 8 0 2 5 6 5 3 |
|---|--|---|---|--|--|--|---|---|--|---------------|
| 1. FOR STATE REGISTRAR  |  |   |   |  | REG. NO.   |  |   |   |  |               |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Roland M. Marine</b>  |  |   |   |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>18</b> YEAR <b>80</b>                               |  |   | 2b. HOUR <b>M</b>   |  |               |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |   | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>6</b> YEAR <b>1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.   |   | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS HOURS <b></b> MIN <b></b>                                   |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |   |   |  |               |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wire Mill</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>  |  |               |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |  |               |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN <b>Dundalk</b>   |  | 13e. STREET ADDRESS <b>51 Wise Avenue</b>  |   |   |  |               |
| 14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b></b> LAST <b>Marine</b>  |  |   |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Ella</b> MIDDLE <b></b> LAST <b></b>                       |  |   |   |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  |   |   |  | 16b. SOCIAL SECURITY NO. <b>WW II 220-03-7221</b>  |  | 17. INFORMANT ADDRESS <b>Irma M. Marine 51 Wise Avenue Balto. MD 21222</b>        |   |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b>  |  |   |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |               |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio Sclerotic &amp; Hypertensive C.V. Dis.</b>   |  |   |   |  |  |  |   |   | 10 yrs                                       |               |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>   |  |   |   |  |  |  |   |   |  |               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>  |  |   |   |  |  |  |   |   |  |               |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M. <b></b> |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |               |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1954</b> to <b>1980</b> , that (I) (we) last saw the deceased alive on <b>08/10</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |   |   |  |               |
| 22b. SIGNATURE <b>Stephen C. Mackowiak</b> DEGREE <b>M.D.</b>   |  |   |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <b>10-21-80</b>  |  |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen C. Mackowiak, M.D.</b>   |  |   |   |  |  | 22e. ADDRESS <b>6714 Holabird Ave., Balto. MD 21222</b>  |   |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |   | 23b. DATE <b>10/22/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodfield Cemetery</b>                                 |  | 23d. LOCATION CITY OR TOWN <b>Galesville</b> COUNTY <b>Maryland</b> STATE <b></b> |   |  |               |
| 24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |               |

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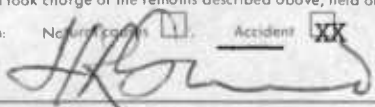
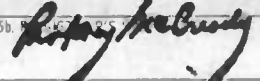
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A13 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80125654

FOR  
1- STATE  
REGISTRAR

|   |  |                  |  |   |  |   |  |   |  |  |  |   |  |                  |  |                       |  |
|---|--|------------------|--|---|--|---|--|---|--|--|--|---|--|------------------|--|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>David   |  | MIDDLE<br>L   |  | LAST<br>Mark  |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED  |  | <input checked="" type="checkbox"/> MONTH<br><input type="checkbox"/> 10 |  | DAY<br>26   |  | YEAR<br>80       |  | 2b. HOUR<br>M<br>2:51 |  |
| 3. SEX<br>male  |  | 4. RACE<br>black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 20 59   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br>YRS.<br>21                  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN  |  | 7c. DATE<br>PRONOUNCED<br>DEAD<br>MONTH DAY YEAR<br>10 26 80  |  | 2d. HOUR<br>2:51 |  |                       |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Trinidad, B.W.I.  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>B.W.I.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |                  |  | MD                    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1501 Shadeside Road |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |                  |  |                       |  |
| 13a. STATE<br>Md.   |  |                  |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Balto.                                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>5719 Winner Avenue                                |  |   |  |                  |  |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harold Farrow   |  |                  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Phyllis M. Hoyte |  |   |  |  |  |   |  |                  |  |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  |  | 16b. SOCIAL SECURITY NO.<br>-   |  | 17. INFORMANT<br>Phyllis M. Hoyte                                 |  |   |  | ADDRESS<br>5719 Winner Avenue  |  |   |  |                  |  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple injuries</u><br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> .<br>(b) _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                  |  |   |  |   |  |   |  |  |  |   |  |                  |  |                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |   |  |   |  |   |  |  |  |   |  |                  |  |                       |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |                  |  |                       |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>2:25AM 10/26/80  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver of auto in collision with fixed object                              |  |  |  |   |  |                  |  |                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>roadway   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>4000Loch RavenBlvd, Baltimore, MD  |  |  |  |   |  |                  |  |                       |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Negligence <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |  |  |   |  |                  |  |                       |  |
| ACTUAL<br>SIGNATURE<br>  |  |                  |  | M.D. Assistant  |  |   |  | MEDICAL EXAMINER  |  |  |  | DATE<br>SIGNED 10/26/80   |  |                  |  |                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.   |  |                  |  | ADDRESS 111 Penn Street, Balto., Maryland   |  |   |  |   |  |  |  |   |  |                  |  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |                  |  | 23b. DATE<br>10/30/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>KING MEM. PARK              |  |   |  | 23d. LOCATION<br>RANDALLSTOWN COUNTY MD.                                 |  |   |  |                  |  |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>WM. C. MARCH F/H, INC.  |  |                  |  | ADDRESS<br>1101 E. NORTH AVENUE   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1980  |  |  |  | 25b. SIGNATURE<br> |  |                  |  |                       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 80 25655<br>REG. NO.  |   |
|---|---|--|--|---|---|
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Henry E Marriott  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>October 18, 1980                    |   | 2b HOUR<br>145 A.M.   |
| 3 SEX<br>male   | 4 RACE<br>C W   | 5 DATE OF BIRTH MONTH DAY YEAR<br>5 3 15   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   | 7 UNDER 1 YEAR<br>MONTHS DAYS<br>7 UNDER 24 HRS<br>HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   | 7b CITIZEN OF WHAT COUNTRY?<br>USA  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                   |   |
| 10 CITY OR TOWN OF DEATH<br>Baltimore Md.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>M.T.C. |   | 12b KIND OF BUSINESS OR INDUSTRY                              |
| 13a STATE<br>Maryland   |   | 13b COUNTY<br>Balt. City   | 13c CITY OR TOWN<br>MIDDLE RIVER                                       | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>JAMES MARRIOTT  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ALICE MYERS   |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNK   |   | 16b SOCIAL SECURITY NO<br>216 01 4060  |  | 17 INFORMANT ADDRESS<br>MARY MARRIOTT ABOVE   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 Cardiopulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) Squamous Cell Carcinoma of the Lung<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 minutes |   |  |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Chronic Obstructive Pulmonary Disease   |   |  |  |   |   |
| 19a DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |   |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22 I certify that (I) (this hospital) attended the deceased from Oct 13, 1980, to Oct 18, 1980, that (I) (we) lost the deceased alive on Oct 13, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                           |   |  |  |   |   |
| 22b. SIGNATURE<br>Lawrence Goldkind MD  |   |  |  | 22c. DATE SIGNED<br>10/18/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lawrence Goldkind MD   |   |  |  | 22e. ADDRESS  |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |   | 23b. DATE<br>10/21/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAK LAWN  |   |
| 23d. LOCATION CITY OR TOWN<br>BALTO.  |   | 23e. COUNTY<br>MD.   |  | 23f. STATE  |   |
| 24 FUNERAL DIRECTOR NAME ADDRESS<br>J.B. CONNELLY 300 MACE  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1980  |   |
|   |   |  |  | 25b. REGISTRAR'S SIGNATURE<br>P. H. H. H.   |   |



Handwritten notes and calculations, including the word "MAY" and some numbers.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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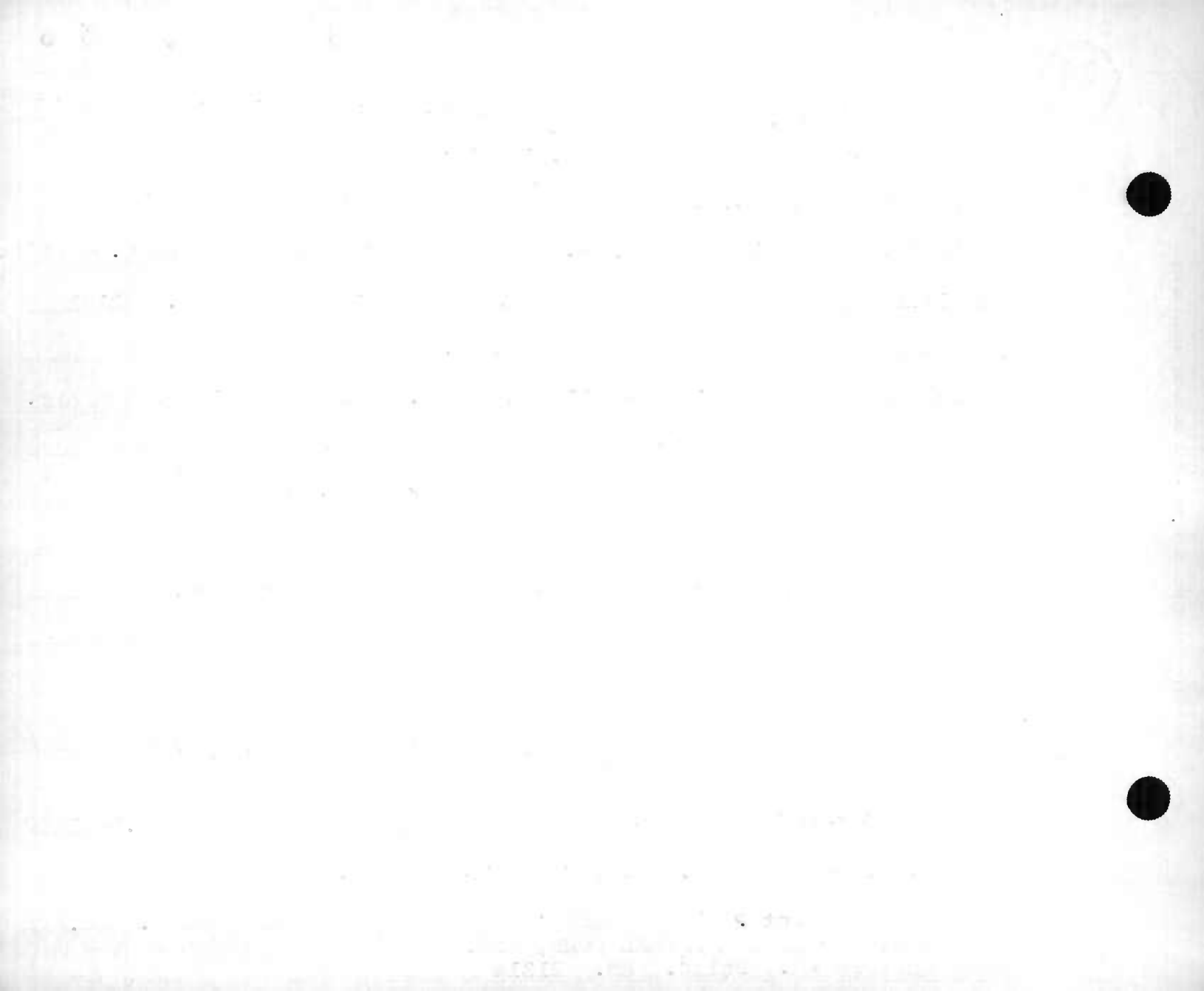
DHM-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 5 6

REG. NO.

|   |  |   |   |                                      |   |
|---|--|---|---|--------------------------------------|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR                             |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR  |   | MONTHS DAYS HOURS MIN                |   |
| PAUL JOSEPH MARSHNER, SR.   |  | October 24, 1980  |   | 7:00 a.m.                            |   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. BALTIMORE CITY OR COUNTY OF DEATH |   |
| Male  | White  | Aug. 13, 1903   | 77 YRS.   | Baltimore City MD.                   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                      |   |
| Washington, D.C.  | U.S.A.   |   | Baltimore City MD.  |                                      |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                      |   |
| Baltimore   | 6013 Sefton Ave.   | Supervisor  | Balto. Gas & Elec   |                                      |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                  |   |
| Maryland  |  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 6013 Sefton Ave. 21214               |   |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |   |                                      |   |
| Otto  | Augusta  | No  |   |                                      |   |
| 16b. SOCIAL SECURITY NO.  | 17. INFORMANT  | ADDRESS   |   |                                      |   |
| 212-05-5911A  | Rovena S. Marshner   | 6013 Sefton Ave.  |   |                                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR Ds</u>   |  |   |   |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Yrs</u> |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ARTERIOSECTOSIS</u>  |  |   |   |                                      | <u>Yrs</u>  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |   |                                      |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>- Central Arteriosclerosis &amp; Senile Dementia</u>  |  |   |   |                                      |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                      |   |
|   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |                                      |   |
|   |  |   |   |                                      |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |                                      |   |
|   |  |   |   |                                      |   |
| 22. I certify that (I) (the hospital) attended the deceased from <u>2-28</u> , 19 <u>80</u> , to <u>10-24</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9-22</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |                                      |   |
| 22b. SIGNATURE  | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 22c. DATE SIGNED                     |   |
| <u>S. J. Venable, Jr.</u>   | <u>M.D.</u>  |   |   | Oct. 24, 1980                        |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS   |   |   |                                      |   |
| S. J. Venable, Jr. M.D.   | 7215 York Rd.  |   |   |                                      |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                                      |   |
| Burial  | Oct 27, 1980   | Parkwood  | Parkville, Balto., Md.  |                                      |   |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE  |                                      |   |
| ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Balto., Md. 21214   |  | OCT 27 1980   | <u>[Signature]</u>  |                                      |   |



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DHMH-16 50M7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 0 2 5 6 5 7

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |  |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MILTON MARSZALKIEWICZ</b>   |  |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>11</b> YEAR <b>80</b>   |  |  | 2b. HOUR <b>9 P M</b>  |  |   |   |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH <b>MAY</b> DAY <b>24</b> YEAR <b>1890</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.                                     |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.                        |  |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2909 FAIT AVE.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LONG SHOREMAN</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>  |   |  |
| 13a. STATE <b>MD.</b>   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>2909 FAIT AVE.</b> |  |
| 14. FATHER'S NAME FIRST <b>MICHAEL</b> MIDDLE <b>MARSZALKIEWICZ</b> LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE LAST  |  |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>215-05-3354</b>  |  | 17. INFORMANT <b>MR. WM. MARSHALL</b> ADDRESS <b>SAME 21224</b>                |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>80</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/1</b> 19 <b>80</b> to <b>10/11</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10/11</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE <b>Bayan B. Elmk</b> DEGREE <b>MD</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <b>10/13/80</b>   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BAYANI B. ELMA</b>   |  |  | 22e. ADDRESS <b>3023 Eastern Ave Balto 21224</b>   |  |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  | 23b. DATE <b>10-15-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM.</b>                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO CO. MD.</b>                                 |   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>THOMAS J. SKARDA</b> ADDRESS <b>2824 HOPSON ST.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 16 1980</b>   |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                      |  |   |   |  |

MEDICAL CERTIFICATION

29

0101 BP



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BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8025658

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALFRED HARRISON MARTIN</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCT 6, 1980</b>   |  | 2b. HOUR<br><b>458 A</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-9-12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>NY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALT. CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALT.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SBGH</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>RIVIERA BCH</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ARTHUR MARTIN</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAE SMITH</b>  |  | 16. ADDRESS<br><b>Pasadena 21122</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-09-5459</b>   |  | 17. INFORMANT<br><b>Timothy M. Martin 1211 Farmview Rd.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>4275</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>ALCOHOLIC CIRRHOSIS</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 1</b> , 19 <b>80</b> , to <b>OCT 6</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>OCT 6</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J. Gillingham MD</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10-6-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JEFF GILLINGHAM</b>   |  | 22e. ADDRESS<br><b>SBGH 3001 Siltanover ST.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/9/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |  | 4001 ADDRESS<br><b>Ritchie Hwy</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Kelly</b>  |  |

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UNITED STATES

DEPARTMENT OF THE ARMY

OFFICE OF THE

ADJUTANT GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 will be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 8 0 2 5 6 5 9<br>REG. NO.   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BURTIS MARTIN</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>10/03/80</b>   |  |  |  |  |
| 3. SEX<br><b>Male</b>   |  |  |  |  | 7b. HOUR <b>11:10a</b>  |  |  |  |  |
| 4. RACE<br><b>Black</b>   |  |  |  |  | 7b. HOUR <b>M</b>   |  |  |  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 13 17</b>   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>                  |  |  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  |  |  |  | 13b. COUNTY<br><b>Balto.</b>  |  |  |  |  |
| 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |
| 13e. STREET ADDRESS<br><b>346 E. 25th Street</b>  |  |  |  |  |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Preston Martin</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lena Jackson</b>  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>251-12-0435</b>  |  |  |  |  |
| 17. INFORMANT<br><b>Ola Martin</b>  |  |  |  |  | ADDRESS<br><b>346 E. 25th Street</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>amyotrophic lateral sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>pneumonia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>bulbar paralysis</b>  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (s) (this hospital) attended the deceased from <b>9/19</b> 19 <b>80</b> , to <b>10/13</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/3</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>R Edwards</b>  |  |  |  |  | 22c. DATE SIGNED<br><b>10/3/80</b>  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R Edwards</b>   |  |  |  |  | 22e. ADDRESS  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  |  | 23b. DATE<br><b>10/10/80</b>  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Park</b>   |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>OCT 6 1980</b>   |  |  |  |  |
| 25b. HEALTH OFFICER'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |  |  |  |   |  |  |  |  |

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[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

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TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 8 0 2 5 6 6 0  |  | REG. NO.   |  |  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CHARLES A. MARTIN SR.  |  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>10 22 80  |  | 2b HOUR<br>3:00 A   |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>WHITE  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>12 19 09   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  | 7 UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3123 WILKENS AVENUE |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RIVET HEATER                   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>BETHLEHEM   |  |
| 13a STATE<br>MARYLAND  |  | 13b COUNTY<br>---  |  | 13c CITY OR TOWN<br>BALTIMORE  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>STEEL<br>3123 WILKENS AVENUE, 21223   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>WILLIAM MARTIN   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>VIRGINIA TOMLIN   |  |  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b SOCIAL SECURITY NO<br>217-03-1747  |  | 17 INFORMANT ADDRESS<br>ANNA A. MARTIN 3123 WILKENS AVENUE, 21223  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of Prostate with<br>185- metastases to pelvis.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>1976                            |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>AS WD  |  |  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from Jan 28 1980 to 10/22 80, that (I) (we) last saw the deceased alive on 10/19 1980, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b SIGNATURE<br>Earl Pass   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | 22c DATE SIGNED<br>10/24/80   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>I. EARL PASS, M.D.   |  | 22e ADDRESS<br>4001 WILKENS AVENUE, 21229  |  |  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  |  | 23b DATE<br>10-25-80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK   |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND                              |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br>HUBBARD FUNERAL HOME, INC.   |  | ADDRESS<br>4107 WILKENS AVE.   |  | 25a DATE REC'D. BY REGISTRAR<br>OCT 24 1980  |  | 25b REGISTRAR'S SIGNATURE  |  |   |  |

GOLF.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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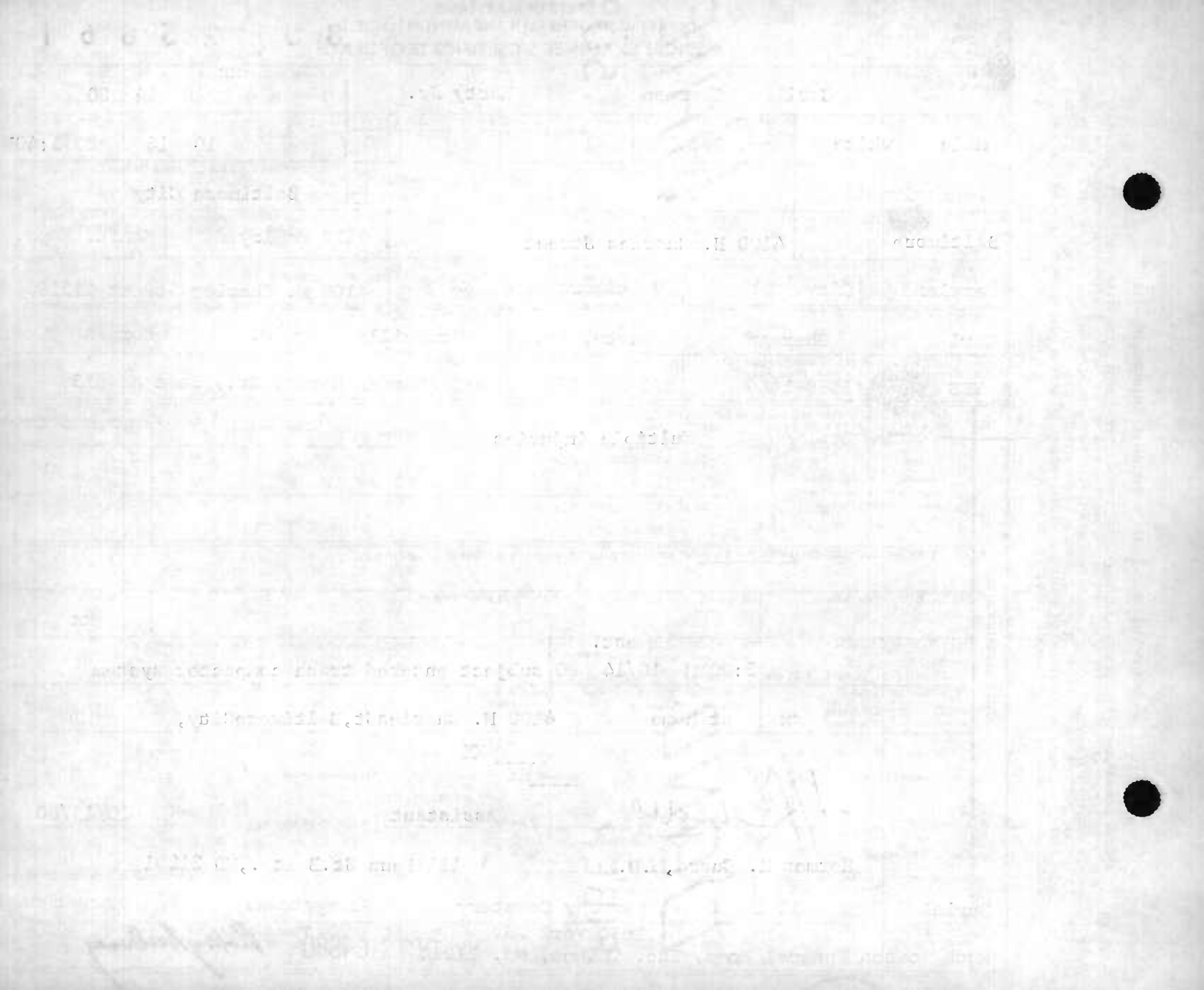
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
|---|---------|--|--------|--|-------------------------|---------------------------------------|------------------|--------------------------------------|--------------------------|---------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  | MIDDLE | LAST                                   | 2a. DATE KNOWN OF DEATH |                                       | ESTIMATED        | MONTH                                | DAY                      | YEAR          | 2b. HOUR                                     |
| Carl Sherman Marty Jr.  |         |  |        |  | XX                      |                                       |                  | 10                                   | 14                       | 1980          | AM   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS)                      | IF UNDER 1 YR.          |                                       | IF UNDER 24 HRS. |                                      | 2c. DATE PRONOUNCED DEAD |               | 2d. HOUR                                     |
| male  | white   | Nov. 29, 1938  |        | 41                                     | MONTHS DAYS HOURS MIN.  |                                       |                  |                                      | 10 14 1980               |               | 3:40 PM                                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |        | 8. MARRIED                             |                         | NEVER MARRIED                         |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH |                          | MD.           |  |
| Pennsylvania  |         | U. S. A.   |        | WIDOWED                                |                         | DIVORCED XX                           |                  | Baltimore City                       |                          |               |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |        | 12a. USUAL OCCUPATION (TYPE OF WORK)   |                         | 12b. KIND OF BUSINESS OR INDUSTRY     |                  |                                      |                          |               |  |
| Baltimore   |         | 4100 N. Charles Street                                   |        | Self Employed                          |                         | Manuf. Reps.                          |                  |                                      |                          |               |  |
| 13a. STATE  |         | 13b. COUNTY  |        | 13c. CITY OR TOWN                      |                         | 13d. INSIDE CITY LIMITS?              |                  | 13e. STREET ADDRESS                  |                          |               |  |
| Maryland  |         | City   |        | Baltimore                              |                         | YES XX NO                             |                  | 4100 N. Charles Street 21218         |                          |               |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                 |        | 16a. SOCIAL SECURITY NO.               |                         | 17. INFORMANT                         |                  | ADDRESS                              |                          |               |  |
| Carl Sherman Marty, Sr.   |         | Priscilla B. Dorman                                      |        | 392-38-9553                            |                         | Carl Sherman Marty, Sr., Same As #13e |                  |                                      |                          |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.                                 |        | 17. INFORMANT                          |                         | ADDRESS                               |                  |                                      |                          |               |  |
| YES   |         | 1960-1966  |        | 392-38-9553                            |                         | Carl Sherman Marty, Sr., Same As #13e |                  |                                      |                          |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |        |  |                         |                                       |                  |                                      |                          |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY:   |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| IMMEDIATE CAUSE (a) Multiple injuries   |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| 9588  |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| (b)   |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| (c)   |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |        |  |                         |                                       |                  |                                      | 20. AUTOPSY?             |               |  |
|   |         |  |        |  |                         |                                       |                  |                                      | YES XX NO                |               |  |
| 21a. EXTERNAL CAUSE WAS   |         | 21b. TIME OF INJURY                                      |        | 21c. HOW INJURY OCCURRED               |                         | 21d. INJURY OCCURRED                  |                  |                                      |                          |               |  |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |         | 3:00 PM 10/14/80   |        | subject entered trash compactor system |                         |                                       |                  |                                      |                          |               |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY                                     |        | 21f. LOCATION                          |                         | 21g. LOCATION                         |                  |                                      |                          |               |  |
| WHILE AT WORK NOT WHILE AT WORK XX  |         | at home  |        | 4100 N. Charles St, Baltimore City, MD |                         |                                       |                  |                                      |                          |               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection Inquiry, and in my opinion death resulted from: Natural causes Accident Suicide XX Homicide Undetermined manner |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |        | DATE SIGNED                            |                         |                                       |                  |                                      |                          |               |  |
| Hormez R. Guard, M.D.   |         | Assistant  |        | 10/15/80                               |                         |                                       |                  |                                      |                          |               |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS  |        |  |                         |                                       |                  |                                      |                          |               |  |
| Hormez R. Guard, M.D.   |         | 111 Penn St. Balto., MD 21201                            |        |  |                         |                                       |                  |                                      |                          |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY     |                         | 23d. LOCATION                         |                  | COUNTY                               |                          | STATE         |  |
| Burial  |         | 10-18-80   |        | Harmony Cemetery                       |                         | Georgetown,                           |                  |                                      |                          | Massachusetts |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR                            |        | 25b. REGISTRAR'S SIGNATURE             |                         |                                       |                  |                                      |                          |               |  |
| NAME  |         | 1050 York Rd.  |        | OCT 16 1980                            |                         |                                       |                  |                                      |                          |               |  |
| Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |         |  |        |  |                         |                                       |                  |                                      |                          |               |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 6 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |   |  |
|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY LEE MASON</b>   |   |   | 2a. DATE OF DEATH<br><b>10/26/80</b>  |   | 2b. HOUR<br><b>11:05 AM</b>   |  |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>NEGRO</b>  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>22</b> YEAR <b>21</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                             |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.             |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nursing Aide</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>  |   |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>Quincy</b> MIDDLE <b>Sankson</b> LAST  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>MARSHALL</b> LAST               |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Anna Beaulieu Sankson / 307 Raymond St</b>                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MASSIVE Upper G.I. Bleeding</b><br><b>5789</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Unknown source of bleeding</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12-24 hrs</b>                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>—</b>   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>no</b>  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>10/26</b> , 19 <b>80</b> , to <b>10/26</b> , 19 <b>80</b> , that (1) (we) lost saw the deceased alive on <b>10/26</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.                                    |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>David C. Allen MD</b>   |   | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>10/26/80</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David C Allen MD</b>   |   | 22e. ADDRESS<br><b>Union Mem'l Hsp 201 E. Univ Parkway Baltimore, MD 21239</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>   |   | 23b. DATE<br><b>11/4/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT AVALON</b>                        |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>  |   |   |   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Marshall A. Hanger 438 N. G. / on N. St</b>  |   |   |   | 25. DATE RECEIVED BY REGISTRAR<br><b>OCT 27 1980</b>                          |   |  |
|  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                              |   |  |

MEDICAL CERTIFICATION

9  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HCZ/M

Y55M

YTD 30 JUL 68

UNION MEMORIAL HOSPITAL

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 6 3

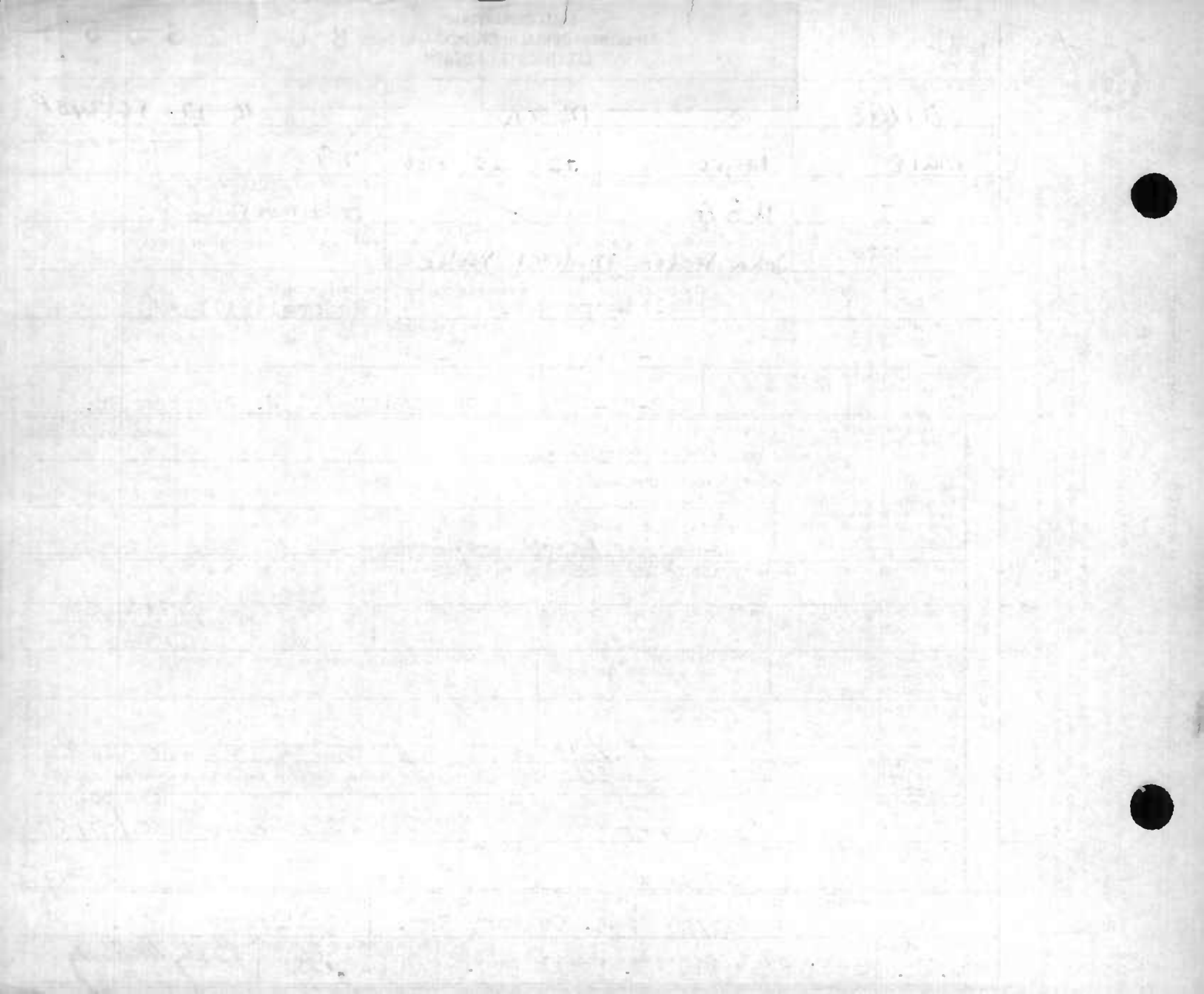
REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Willie Mason</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 17 80</i>  |  | 2b. HOUR<br><i>3:45 P<sup>M</sup></i>  |
| 3. SEX<br><i>MALE</i>   | 4. RACE<br><i>NEGRO</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 25 1900</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>79</i>                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>-</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>John Peaton Medical Center</i> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13a. STATE<br><i>MD</i>   | 13b. COUNTY  | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13e. STREET ADDRESS<br><i>Federal Hill N/H</i>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>218-01-7698</i>  |   | 17. INFORMANT ADDRESS<br><i>Joyce Baylor 301 W. Preston St.</i>                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br><i>7670</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pressure ulcers</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic brain syndrome</i> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 28</i> 19 <i>80</i> , to <i>Oct. 17</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>Oct 17</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Julian W. Reed M.D.</i>  |  | DEGREE  |   | 22c. DATE SIGNED<br><i>10/17/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JULIAN W. REED M.D.</i>   |  | 22e. ADDRESS<br><i>511 S. CHAS. ST. BALTO. MD. 21230</i>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   | 23b. DATE<br><i>10/22/80</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary Cem.</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore Co. MD</i>          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H 1101 E. North Ave.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 22 1980</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>L. H. H. H. H. H.</i>                         |  |

MEDICAL CERTIFICATION

9  
9

2703 BP



**NAME:** Pearl T. Matheny

**DATE OF DEATH:** October 22, 1980

**PLACE OF DEATH:** Baltimore City

**SEE:** #80-25666

DRMH 2485 - Vit. Rec.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |   |                                    | 8 0 2 5 6 6 4   |  |  |  |
|---|--|--|--|--|--|---|--|---|------------------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |   |  |   |                                    | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Baby Boy Matthews</i>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 5 80</i>                    |   |  |   | 2b. HOUR<br>MIN.<br><i>11:30 P</i> |   |  |  |  |
| 3. SEX<br><i>M</i>  |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 5 80</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>0 30</i>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><i>0 30</i>                                 |                                    | IF UNDER 24 HRS<br>HOURS MIN.<br><i>0 30</i>  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore</i> MD.                                    |  |   |                                    |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University of Md. Hospital</i> |  |  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>NA</i> |                                    | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>NA</i>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><i>Md.</i>  |  | 13b. COUNTY<br><i>BALTO</i>  |  | 13c. CITY OR TOWN<br><i>BALTO</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>265 Exeter St. Apt. 9E</i>                          |                                    |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>3000</i>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Deborah Matthews</i> |   |  |   |                                    |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>—</i>                                     |   | 17. INFORMANT<br>ADDRESS<br><i>S. Mumper, Univ. of Md Hospital</i> |   |                                    |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>7651 cardio pulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>prematurity</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>—</i>  |  |  |  |  |  |   |  |   |                                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |   |                                    |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |                                    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |                                    |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                                    |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 5</i> , 19 <i>80</i> , to <i>Oct 5</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>Oct 5</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |                                    |   |  |  |  |
| 22b. SIGNATURE<br><i>S. Mumper</i>  |  |  |  | DEGREE<br><i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><i>10/6/80</i>  |                                    |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Susan Mumper</i>  |  |  |  | 22e. ADDRESS<br><i>University of Md. Hospital</i>  |  |   |  |   |                                    |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Removal</i>  |  |  |  | 23b. DATE<br><i>10/16/80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                    |                                    |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Anatomy Board</i>  |  |  |  |  |  | ADDRESS<br><i>Balto., Md.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 20 1980</i>                           |                                    | REGISTRAR'S SIGNATURE<br><i>Anthony M. ...</i>  |  |  |  |

15

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

Anthony Bond  
Palto, W.

10/16/80

Palto, W.

OCT 20 1980

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 6 6 5  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |   |  |  |
|---|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MYRON F. MARRINOWS</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 13 80</b>                     |   |  | 2b. HOUR<br><b>6:30 AM</b>   |   |  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>NOGR</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>8 28 20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALCO MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2922 NORFOLK AVE</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FORK L. OPER. CHENIERE</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel C. MARRINOWS</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNIE L. LEVINE</b> |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>710-09-6403</b>                          |   | 17. INFORMANT ADDRESS<br><b>ANNIE MARRINOWS 2922 NORFOLK AVE</b>               |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Liposarcoma</b><br>1719<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>80</b> , to <b>Sept 25</b> , 19 <b>80</b> , that (I) <del>lost</del> saw the deceased alive on <b>Sept 25</b> , 19 <b>80</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above; (I) <del>was not</del> did not view the body after death. |  |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Marshall A. Levine MD</b>  |  |  | DEGREE<br><b>MD</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>10/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marshall A. Levine</b>  |  |  | 22e. ADDRESS<br><b>711 W. 40th St Balto MD 21211</b>                    |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>10/10/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Rose</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>                               |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Marshall A. Levine</b>   |  |  | ADDRESS<br><b>636 N. Guilmon St</b>                                     |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 (if any) be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

DHM-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 6 6 6  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>PEARL T. MATTHEW</b>  |  | 2a. DATE OF DEATH MONTH DAY YEAR 10-22-80  |  |
| 3. SEX <b>FEMALE</b>  |  | 2b. HOUR 9:20 PM   |  |
| 4. RACE <b>WHITE</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 5 2 1919  |  | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>CHURCH HOSPITAL</b>                                   |  |
| 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>BALTIMORE</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>ALEXANDER SALEFSKY</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA LAWRENCE</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT ADDRESS <b>JOANN FREIRE 16 N. DECKER AVE.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY: <b>CARCINOMA OF LEFT BREAST WITH METASTASIS</b><br>IMMEDIATE CAUSE (a) <b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEMIPLEGIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE MYOCARDIAL INFARCTION, CARDIOVASCULAR ACCIDENT WITH RIGHT</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>ACUTE MYOCARDIAL INFARCTION, CARDIOVASCULAR ACCIDENT WITH RIGHT</b>   |  |  |  |
| 19a. DATE OF OPERATION <b>8-6-80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PARTIAL MASTECTOMY AND AXILLARY, MAMMARY GLAND DISSECTED</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-4</b> <b>10-22</b> <b>80</b> , to <b>10-22</b> <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10-22</b> <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22c. DATE SIGNED <b>10-22-80</b>   |  |
| 22b. SIGNATURE <b>Dr. A. F. Nour</b> DEGREE <b>MD</b>   |  | 22c. DATE SIGNED <b>10-22-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. A. F. NOUR, MD</b>   |  | 22e. ADDRESS <b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231</b>                        |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>   |  | 23b. DATE <b>10/25/1980</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEM.</b>  |  | 23d. LOCATION <b>BALTIMORE MD.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b> ADDRESS <b>2525 FLEET ST.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1980</b>   |  |
|   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

MEDICAL CERTIFICATION

0802

8

12/17/78



0802 12/17/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |  |   |  |  |  |  |
|---|--|---|---|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANTHONY G. MATULONIS SR.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 02 80</b>                        |   |  | 2b. HOUR<br><b>10:12 M</b>   |   |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 04 10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2667 WILKENS AVENUE</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STEELWORKER</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BETHLEHEM</b>  |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>STEEL<br/>2667 WILKENS AVENUE, 21223</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE MATULONIS</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ALICE UNKNOWN</b>   |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-09-0566</b> |   | 17. INFORMANT<br>ADDRESS<br><b>ANGELINA G. MATULONIS 2667 WILKENS AVENUE</b> |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden death - Massive myo-</b><br><b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary infarction, Hypertensive</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>A.S.E.V.D. One old CVA</b> |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>10-2</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Sept 15</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Stanley Ankudas</b>  |  |   | DEGREE<br><b>M.D.</b>   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>10.3.80</b>                                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STANLEY ANKUDAS, M.D.</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>1101 MAIDEN CHOICE LANE</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>ENTOMBMENT</b>  |  |   | 23b. DATE<br><b>10-06-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                     |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |   | ADDRESS<br><b>4107 WILKENS AVE.</b>   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 3 1980</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                   |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 6 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |
|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUIS DAVID MAZER MAZUR</b>  |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>7</b> YEAR <b>80</b>   |   | 2b. HOUR<br><b>3:00</b> <sup>AM</sup>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>29</b> YEAR <b>09</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>XXXXXX MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                       |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  | 12. BUREAU OF ENGINEERING DIVISION OF CITY OR COUNTY OF BALTO.<br><b>XXXXXXXXXXXXXXXXXXXX</b>   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>XXXXXXXXXXXXXXXXXXXX</b><br><b>GREENSPRING</b> 4242 LABYRINTH |
| 14. FATHER'S NAME<br>FIRST <b>BENJAMIN</b> MIDDLE <b>MAZUR</b> LAST <b>MAZUR</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>LILLIAN</b> LAST <b>ARNSTEIN</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-26-2886</b>   |   | 17. INFORMANT <b>MRS. MATILDA BERMAN</b><br><b>4242 LABYRINTH RD. BALTO., MD 21215</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY ARTERY DISEASE</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIO RESPIRATORY ARREST</b><br><b>ARTHEROSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>CARCINOMA OF PROSTATE WITH BONY METASTASES</b> |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>10-1-80</b> to <b>10-7-80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-7-80</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |
| 22b. SIGNATURE<br><b>STEVEN GREENWALD</b>   |  | DEGREE <b>9075</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |   | 22c. DATE SIGNED<br><b>10-7-80</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN GREENWALD</b>  |  | 22e. ADDRESS<br><b>SINAI HOSPITAL</b><br><b>DELVEDEER AT GREENSPRING</b><br><b>BALTIMORE MARYLAND 21215</b>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  | 23b. DATE<br><b>OCT 8, 1980</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HEBREW YOUNG MEN</b>  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE                     |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br><b>REISTERSTOWN RD. BALTO., MD 21215</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1980</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |   |   |

6010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



31

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80 25669

|  |  |                         |  |   |  |  |  |   |   |   |  |   |  |  |
|--|--|-------------------------|--|---|--|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Kevin D Mazyck</b>   |  |                         | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>10 6 19 80</b>                                       |   |  | 2b. HOUR<br>M<br><b>2:57A</b>  |  |   |   |   |  |   |  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 16 59</b>                       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>20 YRS.</b>  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>10 6 19 80</b>                                       |   |   |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>(side) 8 North Pulaski Street</b> |   |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br><b>MD</b>  |  |                         | 13b. COUNTY  |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET ADDRESS<br><b>4231 park Hghts.</b>                                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Mazyck</b>  |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Hawkins</b>   |  |   |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>214-62-6454</b>                              |  |  |  | 17. INFORMANT ADDRESS<br><b>Lubertha hawkins 1829 W. Vine St.</b>                                     |   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple stab wounds</b><br>966-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |   |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |  |   |  |  |  |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |  |  |  |   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 10/6 19 80</b> |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>found stabbed</b> |   |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>alley</b> |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>8 N. Pulaski Street, Baltimore City MD</b>    |   |   |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                         |  |   |  |  |  |   |   |   |  |   |  |  |
| ACTUAL SIGNATURE<br><i>H R Guard</i>   |  |                         |  |   |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |   | DATE SIGNED<br><b>10/6/80</b>   |  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>  |  |                         |  |   |  | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>  |  |   |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>10/10/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b>   |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balt. County MD.</b> |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Avenue</b>   |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 7 1980</b>   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Jeffrey M. ...</i>                   |  |   |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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March 1941

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March 1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8025670<br>REG. NO.   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Mazzei Lucille M. Mazzei  |  |   |  | 2b. HOUR<br>3:20 AM   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8/28/14  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>66  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Balt. Md.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hosp |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bank Clerk   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Merc. Bank   |  |
| 13a. STATE<br>Maryland  |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John T. Newsome  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Grace Meeks   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>217-16-5649   |  | 17. INFORMANT<br>Shirley Moslak   |  | ADDRESS<br>300 Joplin Street<br>Balto. MD 21224   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br><u>2028</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <u>Lymphoma, Anemia</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR/A.M. MONTH DAY YEAR<br>3:22 PM 10 1 1980   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/3/80</u> , 19 <u>80</u> , to <u>10/1</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Melvin Welinsky M.D.  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>10/1/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Melvin Welinsky  |  |   |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10/4/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR Duda-Ruck, Inc. NAME ADDRESS<br>7922 Wise Avenue, Dundalk, MD 21222  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 2 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Welinsky  |  |

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20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

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301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400

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701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled out by the funeral director and should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25671

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |
| CLARA   |  | MCCALLUM   |  | OCTOBER 24, 1980  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |
| Female  |  | Negro  |  | 3 24 01   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| N.C.  |  | USA  |  | 79 YRS.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Baltimore   |  | THE JOHNS HOPKINS HOSPITAL   |  | BALTIMORE CITY MD.  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. INSIDE CITY LIMITS?   |  | 13b. STREET ADDRESS   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| MD  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |  |
| John Harrington   |  | Judy   |  | No  |  |
| 16b. SOCIAL SECURITY NO.  |  | 16c. INFORMANT   |  | ADDRESS   |  |
| 217-22-2256   |  | Doretha Richardson   |  | 1517 N. Kenwood Ave.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  | 5 minutes   |  |
| IMMEDIATE CAUSE (a) <i>Cardiovascular arrest</i>  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  | 1 week  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |   |  |
| (b) <i>Possible sepsis - bacterial</i>  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |
| (c)   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |
| <i>Bilateral Cardiovascular Accidents</i>   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  |
|   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                |  |
|   |  | P.M. 19  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
|   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/16</i> , 19 <i>80</i> , to <i>10/24</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10/24</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| <i>Anthony Elias</i>  |  | MD   |  | 10/24/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  |
| ANTHONY ELIAS   |  | JOHNS HOPKINS HOSPITAL   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 10/31/80   |  | Baltimore Cemetery  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. SIGNATURE  |  |
| Wm. C. March f/h 1101 E. North Ave.   |  | OCT 27 1980  |  | <i>Anthony Elias</i>  |  |

*[Faint, illegible handwriting]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
|---|--|------------------------------|--|--|--|--|--|------------------------------------|--|------------------|--|---|--|--|--|---|--|-------------------|--|---|--|---------------------|--|---------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST                        |  | MIDDLE   |  | LAST   |  | 2a. DATE KNOWN<br>OF DEATH         |  | ESTI-<br>MATED   |  | MONTH   |  | DAY  |  | YEAR  |  | 2b. HOUR          |  |   |  |                     |  |         |  |  |  |
| ST. LOUIS   |  |                              |  |  |  | MC CARLO   |  | 10                                 |  | 1                |  | 19  |  | 80   |  |   |  | M                 |  |   |  |                     |  |         |  |  |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.                     |  | IF UNDER 24 HRS. |  | 2c. DATE<br>PRONOUNCED<br>DEAD  |  | MONTH                                      |  | DAY   |  | YEAR              |  | 2d. HOUR  |  |                     |  |         |  |  |  |
| male  |  | negro                        |  | 7 8 22   |  | 58 YRS.  |  |                                    |  |                  |  | 10  |  | 1  |  | 19  |  | 80                |  | 5:09 P M  |  |                     |  |         |  |  |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |  | NEVER MARRIED  |  | WIDOWED                            |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| Saxton Va   |  | USA                          |  |  |  |  |  |                                    |  |                  |  | Baltimore City MD   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |                                    |  |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |  |  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |                   |  |   |  |                     |  |         |  |  |  |
| Baltimore   |  |                              |  | 1703 Appleton St.  |  |  |  |                                    |  |                  |  | Lumber  |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| 13a. STATE  |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS |  |         |  |  |  |
| MD  |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  | Baltimore         |  |   |  | 1703 Appleton St    |  |         |  |  |  |
| 14. FATHER'S NAME   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |                   |  |   |  |                     |  |         |  |  |  |
| Ernest B McCarlo  |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  | Alice Richardson  |  |                   |  |   |  |                     |  |         |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  | 16b. SOCIAL SECURITY NO.  |  |                   |  | 17. INFORMANT   |  |                     |  | ADDRESS |  |  |  |
| no  |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  | 223-22-6709   |  |                   |  | Alice McCarlo 1703 Appleton St  |  |                     |  |         |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of throat</u><br>1490<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| 19a. DATE OF OPERATION  |  |                              |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |  |                                    |  |                  |  |   |  |  |  | 20. AUTOPSY?  |  |                   |  |   |  |                     |  |         |  |  |  |
|   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                   |  |   |  |                     |  |         |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                              |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |  |                                    |  |                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
|   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                              |  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) |  |                                    |  |                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
|   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| ACTUAL<br>SIGNATURE   |  |                              |  |  |  | TITLE (SPECIFY)<br>Assistant                                   |  |                                    |  |                  |  | DATE<br>SIGNED  |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| Ann M. Dixon, M.D.  |  |                              |  |  |  | MEDICAL EXAMINER   |  |                                    |  |                  |  | 10-3-80   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |                              |  |  |  | ADDRESS  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| Ann M. Dixon, M.D.  |  |                              |  |  |  | 111 Penn St.   |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |                              |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |                  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| Burial  |  |                              |  |  |  | 10/7/80  |  | Mt Auburn                          |  |                  |  |   |  | Baltimore MD                               |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| 24. FUNERAL DIRECTOR  |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| Thomas P. Rapp 238 Dg. St   |  |                              |  |  |  |  |  |                                    |  |                  |  |   |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR   |  |                              |  |  |  |  |  |                                    |  |                  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |
| OCT 3 1980  |  |                              |  |  |  |  |  |                                    |  |                  |  | Fitzgerald  |  |  |  |   |  |                   |  |   |  |                     |  |         |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                          |  |  | REG. NO. 80 25673   |  |
|--|--------------------------|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>HENRY GEORGE McCLELLAND</b>  |                          | 2a. DATE OF DEATH MONTH DAY YEAR <b>10-17-80</b>   |  | 2b. HOUR <b>2:30 AM</b>   |  |
| 3. SEX <b>MALE</b>   | 4. RACE <b>CAUCASIAN</b> | 5. DATE OF BIRTH MONTH DAY YEAR <b>06-10-05</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>  |                          | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE MD.</b>   |                          | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALT. CITY HOSP.</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY, MD.</b>   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>   |                          | 12b. KIND OF BUSINESS OR INDUSTRY <b>MEAT CO.</b>  |  | 13a. STREET ADDRESS <b>7037 EASTBROOK AVE.</b>  |  |
| 13a. STATE <b>MD.</b>  |                          | 13b. COUNTY <b>BALTO.</b>  |  | 13c. CITY OR TOWN <b>EASTWOOD</b>   |  |
| 14. FATHER'S NAME FIRST <b>JOHN H.</b> MIDDLE <b>McCLELLAND</b> LAST   |                          | 15. MOTHER'S MAIDEN NAME FIRST <b>EMMA</b> MIDDLE <b>LAMMERS</b> LAST  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |
| 16b. SOCIAL SECURITY NO <b>213-03-9239A</b>  |                          | 17. INFORMANT <b>KATHRYN M. McCLELLAND</b>   |  | ADDRESS <b>7037 EASTBROOK AVE. EASTWOOD, 21224, MD.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Pub. Gid. inc.</b><br><b>5789</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute Cardiac arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>UGT bleed.</b> |                          |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Abd. Anomalous</b>  |                          |  |  |   |  |
| 19a. DATE OF OPERATION   |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                          |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                          | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                          | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/24</b> 19 <b>80</b> , to <b>10/17</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/17</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                          |  |  |   |  |
| 22b. SIGNATURE <b>[Signature]</b>  |                          | DEGREE   |  | 22c. DATE SIGNED <b>10/17/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. JAIN</b>   |                          | 22e. ADDRESS <b>Balt. City Hosp</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                          | 23b. DATE <b>10-20-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>   |  |
| 23d. LOCATION CITY OR TOWN <b>7401 GERMAN HILL RD. BA. CO., MD</b>   |                          | COUNTY   |  | STATE   |  |
| 24. FUNERAL DIRECTOR NAME <b>Charles L. Geiler &amp; Son, Inc.</b>   |                          | 6224 EASTERN AVE. BALTO., 21224, MD.   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 20 1980</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |                          |  |  |   |  |

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(JAMES GEORGE HOGAN)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25674  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELLEASE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 9, 1980</b>          |   |  | 2b. HOUR<br>M<br><b>AM</b>   |   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 5 40</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>40</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LUTHERAN HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                    |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Reese McFadden</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Thomas</b>    |   |  | 13e. STREET ADDRESS<br><b>1710 Edmondson Ave.</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO (UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>249-68-5668</b>                         |   | 17 INFORMANT<br>ADDRESS<br><b>Roosevelt McFadden 1710 Edmondson Ave.</b> |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cor Pulmonale</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHF</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hr.</b><br><b>3 yr.</b><br><b>3 yr.</b>                               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Sarcoidosis</b>   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 80</b> to <b>Oct 9 80</b> , that (I) (we) last saw the deceased alive on <b>Oct 1 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>James H. Milman M.D.</b>  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Oct. 9, 1980</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James H. Milman, M.D.</b>  |  |   | 22e. ADDRESS<br><b>University of Md. Hospital, Baltimore 21201</b>     |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>10/11/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Family Plot</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>New Zion S.C.</b>                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>                                   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>   |  |

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(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 7 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Blanche P. McFarland</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 8 80</i>                  |   |  | 2b. HOUR<br><i>1 45 PM</i>   |  |  |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>2 4 03</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>77</i> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Virginia</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>US</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Md. Balto.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>DEATON MEDICAL CENTER</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><i>Md.</i>  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><i>Balto.</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>111 West Centre Street</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John W. Saum</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ellen</i>          |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Unkn.</i>  |  |   | 16b. SOCIAL SECURITY NO.<br><i>219-30-9708</i>                         |   | 17. INFORMANT ADDRESS  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ASCVD</i><br><i>2500</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Diabetes Mellitus</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Pressure Ulcers</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 8</i> , 19 <i>80</i> , to <i>Oct 8</i> , 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>Oct 8</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Julian W. Reed</i>   |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>10/8/80</i>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JULIAN W. REED MD</i>   |  |   | 22e. ADDRESS<br><i>611 S. CHAS. ST. BALTO. MD</i>                      |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Removal</i>   |  |   | 23b. DATE<br><i>10/8/80</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Anatomy Board</i>  |  |   |  |   | ADDRESS<br><i>Balto., Md.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 14 1980</i>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert Helms</i>    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

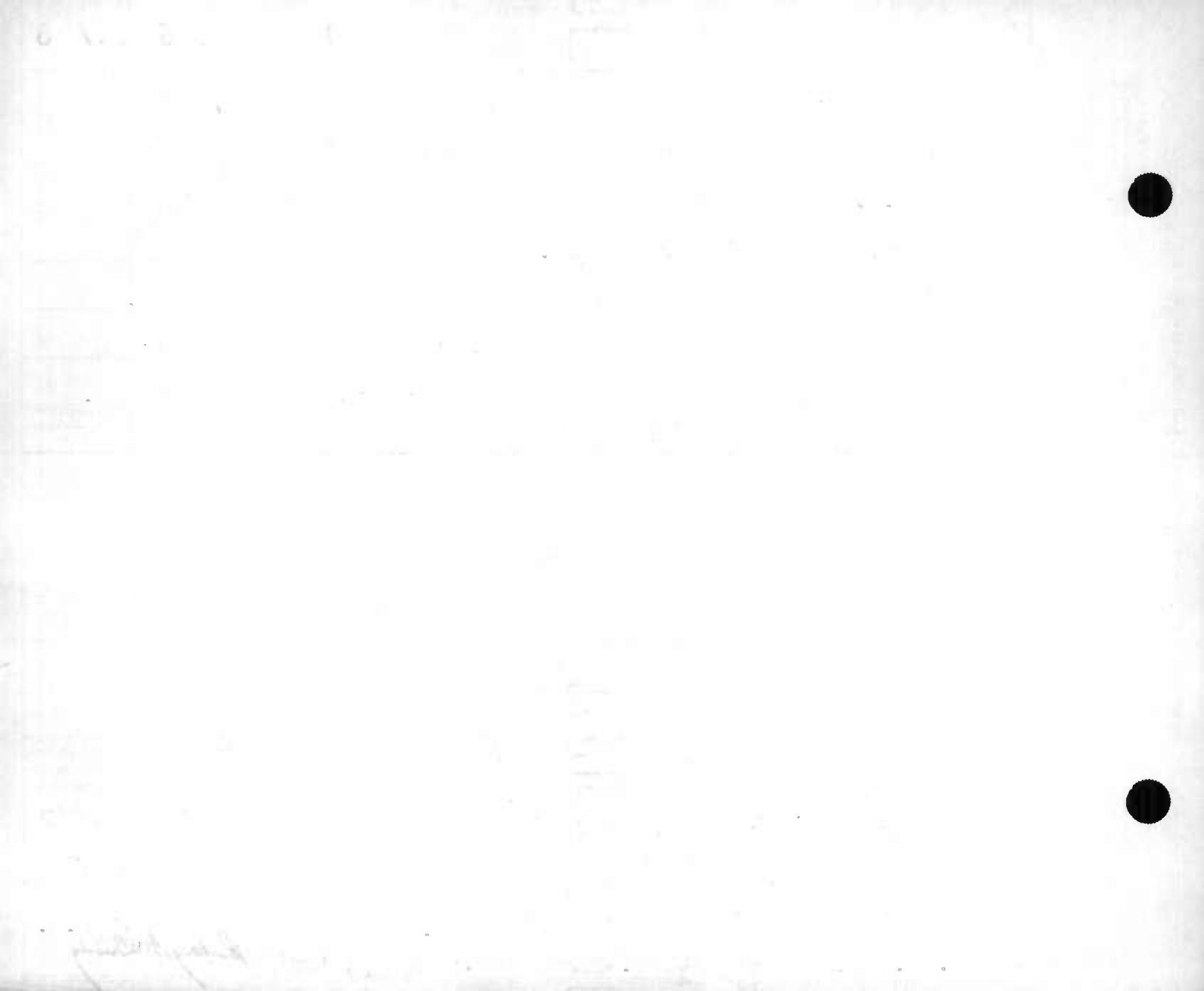
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 7 6

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EARLY</b>  |  | FIRST MIDDLE LAST<br><b>MC LEAN</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 12, 1980</b>   |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 6 24</b>  |  | 6. AGE IN YEARS (LAST BIRTHDAY)<br><b>56</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3213 Prestman St.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY   |  | 13c. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>3213 Prestman St.</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Jack McLean</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lucy Dixon</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>243-26-5197</b>  |  | 17. INFORMANT ADDRESS<br><b>Rosalee McLean 3213 Prestman St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>hypertension &amp; arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1978</b> , 19____, to <b>9/27/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>9/27/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J. S. Shorofsky M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lo SPOROFsky, M.D.</b>   |  | 22e. ADDRESS<br><b>4734 Park Heights Rd 21215</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/20/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Springhill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hope Mills N.C.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 2 5 6 7 7   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN Wesley McLean</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 21 80</b>  |  | 2b. HOUR<br><b>9:30 A.M.</b>  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 3 19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secour Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert McLean</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie McNeill</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>243-01-7466</b>  |  | 17. INFORMANT ADDRESS<br><b>Martha Snead 1376 Bryant St. N.E.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b>   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/18</b> 19 <b>80</b> to <b>10/21</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/20</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Kuang-Yen Huang M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>10/21/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |  |   |  | 22e. ADDRESS<br><b>BON SECOURS Hospital</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/25/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. G. March</b>   |  |   |  | ADDRESS<br><b>101 E. NORTH</b>  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>OCT 22 1980</b>  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |                     | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 0 2 5 6 7 8<br>REG. NO.  |  |
|--|---------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>BETTY A. McLEOD</i>   |                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 30 80</i>  |  | 2b. HOUR<br><i>12:08 P.M.</i>  |  |
| 3. SEX<br><i>F</i>   | 4. RACE<br><i>B</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 8 37</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>43</i>   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |                     | 8. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>U. of Maryland Hospital</i>   |  | 12. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Assembly line work</i>   |  |
| 13a. STATE<br><i>Md.</i>   |                     | 13b. COUNTY<br><i>Balt.</i>   |  | 13c. CITY OR TOWN<br><i>Balt.</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>CHARLES STEWART</i>   |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>CARRIE JOHNSON</i>  |  | 16. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 17. SOCIAL SECURITY NO.<br><i>216-34-3985</i>  |                     | 18. INFORMANT<br><i>Mrs. Carrie Gibbs</i>   |  | 19. ADDRESS<br><i>3729 Towanda Ave.</i>  |  |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Metastatic Breast Cancer</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                     | 21. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 22a. DATE OF OPERATION<br><i>12-28-80</i>  |                     | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Metastatic to spine</i>  |  | 22c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                     | 23b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |
| 24a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     | 24b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 24c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>22 Green St. Balt. Md. 21201</i>       |  |
| 25a. I certify that (I) (this hospital) attended the deceased from <i>7-9</i> , 19 <i>80</i> , to <i>10-30</i> , 19 <i>80</i> , that (I) (we) lost the deceased alive on <i>10-30</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |                     | 25b. SIGNATURE<br><i>Don M. Morris</i>  |  | 25c. DATE SIGNED<br><i>10-30-80</i>  |  |
| 26a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DON M. MORRIS M.D.</i>   |                     | 26b. ADDRESS<br><i>22 Green St. Balt. Md. 21201</i>   |  | 26c. REGISTERAR'S SIGNATURE<br><i>Pistay Hebrudy</i>   |  |
| 27a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |                     | 27b. DATE<br><i>11-4-80</i>   |  | 27c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Calvary</i>                                       |  |
| 28a. FUNERAL DIRECTOR NAME<br><i>Chas. A. Rice FSPA 1300 Eutaw Pl.</i>   |                     | 28b. DATE REC'D. BY REGISTRAR<br><i>NOV 7 1980</i>  |  | 28c. REGISTERAR'S SIGNATURE<br><i>Pistay Hebrudy</i>   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. 25679  |  |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Love (McNahan) McMahan |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>10 27 1980   |  | 2b. HOUR<br>M<br>4:28P  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 9 16  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>64 YRS.   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10 27 1980  |  | 2d. HOUR<br>M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE MD   |  |   |  | 12b. COUNTY<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>663 Gutman Avenue  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jackson Erving   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Moore                                    |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>246-22-4895   |  | 17. INFORMANT ADDRESS<br>James Morgan 663 Gutman Ave.   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY)<br>Deputy Chief MEDICAL EXAMINER  |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |  |   |  | DATE SIGNED<br>10/28/80   |  |   |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |   |  | ADDRESS<br>111 Penn St. Balto., MD.   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>11/1/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN<br>Baltimore  |  | 23e. STATE<br>MD  |  |
| 24. FUNERAL DIRECTOR<br>(NAME)<br>Wm. C. March F/H   |  |   |  | ADDRESS<br>1101 E. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1980  |  | 25b. REGISTRAR<br>(Signature)   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  | 8 0 2 5 6 8 0   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JONAS A McMillan Sr.</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>10/11/80</b>  |  |  |  | 2b. HOUR <b>2:40Am</b>                                |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 4 11</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                         |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Md Hosp.</b> |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                     |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>5515 Price Ave</b>   |  |   |  |  |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |   |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Isaac McMillan</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Jackson McMillan</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>245-07-2412</b>  |  | 17. INFORMANT ADDRESS<br><b>Joseph McMillan 5515 Price Ave.</b>   |  |   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br><b>496 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Obstructive lung disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Congestive Heart Failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>13yr</b><br><b>5yr</b> |  |  |  |   |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Slp @ Pneumonectomy for Carcinoma</b>  |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 5</b> , 19 <b>80</b> , to <b>Oct 11</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>Oct 11</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Christine Frieburg Hernandez MD</b>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/11/80</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHRISTINE FRIEBURG HERNANDEZ</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>22 Greene St. UofMd Hosp Balto. Md</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>10/16/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>   |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Christy Frieburg</b> |  |  |  |

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

SUBJECT: [Illegible]

REFERENCE: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

[Illegible]

*[Handwritten signature]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | LAKESHA A. MC MILLION  |  | OCTOBER 12, 1980  |  | 1:08 PM  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  |
| Female   |  | Negro  |  | MONTH DAY YEAR<br>4 28 80  |  | YRS. MONTHS DAYS  |  | IF UNDER 72 HRS. HOURS MIN.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |
| MD   |  | USA  |  |  |  | BALTIMORE CITY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  |  |  |
| Baltimore  |  | THE JOHNS HOPKINS HOSPITAL   |  |  |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |  |  |
|  |  |  |  |  |  |   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| MD   |  | BALTIMORE  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 315 E. 22nd. St.   |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |  |  |   |  |  |  |
| Joseph McMillion   |  | Caroline Roberson  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |
| No   |  | N/A  |  | Caroline Roberson 315 E. 22nd. St.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE   |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CONGENITAL HEART DISEASE (VSD)  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
|  |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
|  |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/26, 1980, to 10/12, 1980, that (I) (we) lost saw the deceased alive on 10/12 (1:08 PM) 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |
| Barbara F. L.  |  |  |  | 10/12/80   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| BARBARA F. L.  |  | JOHNS HOPKINS HOSPITAL   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |
| Burial   |  | 10/17/80   |  | Mt. Auburn Cem.  |  | Baltimore MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.  |  | OCT 15 1980  |  | Barbara F. L.  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18c G550 12/15/80 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 8 2

REG. NO.

|   |                        |  |  |  |   |   |   |  |
|---|------------------------|--|--|--|---|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>WALTER L. MEEHAN</b>   |                        |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 28 80</b>  |  |   | 2b HOUR<br><b>2 P</b>   |   |  |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>WHITE</b> | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 - 1 - 11</b> | 6 AGE (IN YEARS LAST BIRTHDAY)<br>MONTHS DAYS HOURS MIN<br><b>69 YRS</b>   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b> |   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |                        |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY MD.</b>   |  |   |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTO</b>  |                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BOON SECOURS Hosp.</b> |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Shipper - Caulker</b> |   |  |
| 12b KIND OF BUSINESS OR INDUSTRY<br><b>Shipyards</b>  |                        |  | 13a STREET ADDRESS<br><b>936 Lemmon St. - 21201</b>  |  |   |   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Meehan</b>   |                        |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bessie Wright</b>   |  |   |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |                        |  | 16b SOCIAL SECURITY NO.<br><b>231-039740</b>   |  |   | 17 INFORMANT<br>ADDRESS<br><b>John L. Meehan 888 W. Lombard St. 21201</b>                   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1490</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br><b>Cardiac arrest</b><br><b>myocardial infarction</b><br><b>Carcinoma Retropharyngeal</b><br><b>pharyngeal cancer</b> |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 mins</b><br><b>30 min</b><br><b>1 yr.</b>  |  |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                        |  |  |  |   |   |   |  |
| 19a DATE OF OPERATION   |                        |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   | 21c HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)            |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                        |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>1970</b> 19____, to <b>10/28/80</b> 19____, that (I) (we) lost<br>saw the deceased alive on <b>10/28/80</b> 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.        |                        |  |  |  |   |   |   |  |
| 22b SIGNATURE<br><b>S. Mueseler M.D.</b>  |                        |  |  |  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>10/28/80</b>  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. Mueseler M.D.</b>   |                        |  |  |  |   | 22e ADDRESS<br><b>5010 Ritchie Hwy. Balt.</b>   |   |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  |                        |  | 23b DATE<br><b>10-31-1980</b>  |  |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Blair Horne Cem.</b>                                |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Blair Horne Md.</b>  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>John J. Corran, Sr. Inc. 901 Shelton St.</b>  |                        |  |  |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>OCT 30 1980</b>  |   | 25b REGISTRAR'S SIGNATURE<br><b>Ritzy Kalman</b>   |



BP  
 DHMH - 16 50M 1/76  
 (VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 7 0 2 5 6 8 3   |  |
|---|--|--|--|---|--|
| 1 - STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |
| Baby Geneveive Elizabeth Meiller  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |
| FIRST MIDDLE LAST<br>meiller Baby Girl  |  |  |  | (Oct.) 10-1-80 2:35 PM  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |
| Female  |  | White  |  | 9-24-80   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. AGE (IN YEARS LAST BIRTHDAY)   |  |
| Baltimore, Md.  |  | U.S.A.   |  | - YRS. MONTHS DAYS  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Baltimore   |  | St. Agnes Hospital   |  | Baltimore, City, MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS   |  |
| none  |  | ---  |  | 910 Sedgley Road  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  |
| Md.   |  | Baltimore  |  | Catonsville   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |
| Joseph J. Meiller   |  | Mary Mengers   |  | No  |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 7718 |  |
| ---   |  | Mr. Joseph J. Meiller-910 Sedgley Rd   |  | Cardio-respiratory failure  |  |
|   |  |  |  | (b) 7718  |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) 7718   |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |
| Progeria Multiple Congenital anomalies  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
|   |  | (P.M.) 10 1 1980   |  | X   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
|   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1980 to 10.1.1980, that (I) (we) lost saw the deceased alive on 10.1.80 2:35 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |
| Chandana Chatterjee   |  | M.D.   |  | 10.2.80.  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 22f. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |
| CHANDANA CHATTERJEE   |  | S.C. Nursery   |  | 10/7/80   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 10/4/80  |  | New Cathedral Cemetery - Baltimore, Md.   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |
| Sterling Funeral Home   |  | 736 Edmondson Ave. Catonsville, Md. 21228  |  | 10/7/80   |  |

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 2 5 6 8 4   |  |   |  |   |  |                              |  |
|---|--|---|--|---|--|---|--|---|--|------------------------------|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |   |  |   |  |                              |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ANTONIO J. MELLO  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCT. 28, 1980  |  |   |  | 2b. HOUR<br>9:50 PM   |  |                              |  |
| 3. SEX<br>M.  |  | 4. RACE<br>NEGRO  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 1 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |  |                              |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                      |  |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MAINTENANCE |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Loyola College  |  |                              |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY MELLO   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NELLIE WATKINS   |  |   |  |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-22-3281  |  | 17. INFORMANT<br>ADDRESS  |  |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>progressive myocardial failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ischemic heart disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Metastatic Pancreatic Carcinoma</u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |                              |  |
|   |  |   |  |   |  |   |  |   |  |                              |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |                              |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |   |  |   |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR-A.M. MONTH DAY YEAR<br>8:45 P.M. 10 28 19 80  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |  |   |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>80</u> , to <u>10/28</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  | 22b. SIGNATURE<br>John Mannisi MD   |  | 22c. DATE SIGNED<br>10/28/80 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John Mannisi MD  |  |   |  | 22e. ADDRESS<br>601 N. BROADWAY BALT. MD  |  |   |  |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>11/1/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>KING MEN PK                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. County Md.                                 |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>LOCKS FUNERAL HOME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 30 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Rafaela M. B...                                   |  |   |  |                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 6 8 5  
CERTIFICATE OF DEATH

|  |  |   |   |
|--|--|---|---|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT) <u>MILDRED L MENK</u>   |  | 2a. DATE OF DEATH MONTH DAY YEAR 10 7 80 3:15 PM  |   |
| 3. SEX <u>F</u>  | 4. RACE <u>W</u>   | 5. DATE OF BIRTH MONTH DAY YEAR <u>Oct 15 1911</u>  | 6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>  | 8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD.  |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>BALTIMORE CANCER RESEARCH CENTER</u> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Beautician</u>   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>MARYLAND</u>   | 13b. COUNTY <u>Dorchester</u>  | 13c. CITY OR TOWN <u>Cambridge</u>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME <u>Ottie LeCompte Boose</u>  | 15. MOTHER'S MAIDEN NAME <u>Catherine Cantwell</u>   | 13e. STREET ADDRESS <u>rural route 1</u>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>  | 16b. SOCIAL SECURITY NO. <u>214-07-7874</u>  | 17. INFORMANT ADDRESS <u>Kathleen Willey RD 1 Bx 59 Camb. Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asystole</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>gram negative sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>out cell carcinoma</u>   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>80</u> , to <u>10/7</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |
| 22b. SIGNATURE <u>H. Geran, M.D.</u>   | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                          | 22c. DATE SIGNED <u>10/7/80</u>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HENRY GERAN, M.D.</u>   | 22e. ADDRESS <u>BALTIMORE CANCER RESEARCH CENTER</u>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>  | 23b. DATE <u>10/9/1980</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem Pk</u>   | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Cambridge Dor. Md.</u>   |
| 24. FUNERAL DIRECTOR <u>Thomas Funeral Home Cambridge Md. 21613</u>  |  | 25a. DATE REC'D. BY REGISTRAR <u>OCT 16 1980</u>  | 25b. REGISTRAR'S SIGNATURE <u>Robert H. Kelly</u>   |

MEDICAL CERTIFICATION

010103



Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |                                |  |   |  |  |
|--|--|---|--|---|--------------------------------|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Brother Clarence W. Merideth, C.S.S.J.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>12 4 80   |   |                                | 2b. HOUR<br>6 <sup>30</sup> A.M.   |   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 2, 1940  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS.                                     |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Missouri  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore Cancer Research Center |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clergy  |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |   | 13b. COUNTY<br>-   |   | 13c. CITY OR TOWN<br>Baltimore |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick C. Merideth  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alvena Scherer  |   |                                |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  |  | 17. INFORMANT<br>ADDRESS<br>Fr. Edward Jackson, same address  |                                |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asystole</u><br>1541<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>metastatic Rectal Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>metastatic Rectal Carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |                                |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/5</u> 19 <u>80</u> to <u>10/4</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                                |  |   |  |  |
| 22b. SIGNATURE<br><u>Henry Gerard, M.D.</u>  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |                                | 22c. DATE SIGNED<br><u>10/4/80</u>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>HENRY GERARD, M.D.</u>   |  |   | 22e. ADDRESS<br><u>22. S. Greene St. Baltimore Cancer Research Center</u>  |   |                                |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>10/7/80</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Most Holy Redeemer</u>   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore Md.</u>             |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>Schimunek Funeral Home, Inc.</u>  |  |   | 25. DATE REC'D. BY REGISTRAR<br><u>2321 Brehms Lane Balto., Md. 21213</u>  |   |                                | 26. DATE REC'D. BY REGISTRAR<br><u>OCT 7 1980</u>                              |   |  |  |

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



*Handwritten signature*

NOV 1910

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH-16 30M 2/80  
(VRA 15,4)



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

-80-

REG. NO.

2 5 6 8 7

|  |  |   |  |   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
|--|--|---|--|---|--|--|--|-----------------------------|--|------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH           |  | MONTH            |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| MIRIAM A. MERRIKEN   |  |   |  |   |  |  |  | 10                          |  | 1                |  | 80    |  |      |  | 6:45 AM  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR             |  | IF UNDER 24 HRS. |  |       |  |      |  |          |  |
| Female   |  | Caucasian   |  | MONTH 3 DAY 5 YEAR 25   |  | 55 YRS.  |  | MONTHS                      |  | DAYS             |  | HOURS |  | MIN. |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                             |  |                  |  |       |  |      |  |          |  |
| Md.  |  | U.S.A.  |  |   |  | Baltimore City   |  |                             |  |                  |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                             |  |                  |  |       |  |      |  |          |  |
| Baltimore  |  | The Good Samaritan Hosp   |  | Homemaker   |  | OWN HOME   |  |                             |  |                  |  |       |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS         |  |                  |  |       |  |      |  |          |  |
| Maryland   |  |   |  | Baltimore   |  |  |  | 1512 Stonewood Rd.          |  |                  |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
| George A. Johnston   |  | Lillian Miller  |  |   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMATION ADDRESS   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
| No   |  | 218-14-5391   |  | LeRoy B. Merriken, Jr.  |  | Balto., Md   |  |                             |  |                  |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest.<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Lung Ca. Extensive metastases<br>(c) Due to, OR AS A CONSEQUENCE OF to pericardium, hepatic colonic LVC, Hepatic vein obstruction |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 months  |  |   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                             |  |                  |  |       |  |      |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/30, 19 80, to 10/1, 19 80, that (I) (we) lost saw the deceased alive on 10/1, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (it) (did not) view the body after death.   |  | 22b. SIGNATURE<br>Jungsin Lee M.D.  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/1/80 |  |                  |  |       |  |      |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WEINER 1 JUNG SIN LEE   |  | 22e. ADDRESS<br>The Good Samaritan Hosp.  |  |   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/4/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. County, Md.   |  |                             |  |                  |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 3 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Rifay McBrady   |  |  |  |                             |  |                  |  |       |  |      |  |          |  |

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UNIT 10

UNIT 10

UNIT 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Colleen B. Meszaros   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 5, 1980  |   |  | 2b. HOUR<br>4:56A M  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>MAY 4, 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>OHIO   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2730 MARYLAND AVE. 21218  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EARL JOHNSTON  |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY McCAHILL  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>218-80-9600   |   | 17. INFORMANT ADDRESS<br>JULIUS J. MESZAROS 2730 MARYLAND AVE.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Failure</u><br><u>410-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Angina Pectoris, Auricular Fibrillation</u>   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 5, 1980</u> , to <u>October 5, 1980</u> , that <input checked="" type="checkbox"/> (we) lost <u>October 5, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Michael Hull M.D.</u>  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br>10/5/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Hull, M.D.   |  |   |   |   | 22e. ADDRESS<br>c/o Maryland General Hospital  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>OCT. 8, 1980   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD CEM.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>PARKVILLE BALTO. MD.                                 |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 9 1980  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Robert McCall</u> |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | 8 0 2 5 6 8 9  |   |                                     |  |
|--|--|--|--|--|--|---|-------------------------------------|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  | REG. NO.   |   |                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>BABY STEVEN D. MEYERS  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10. 17 80                |   |                                     | 2b. HOUR<br>7:55 P.M.                        |
| 3 SEX<br>Male  |  | 4 RACE<br>Caucasian  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>09 03. 80  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br>1 14  |                                     | 7. UNDER 1 YEAR<br>HRS MIN                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |                                     |  |
| 10 CITY OR TOWN OF DEATH<br>Balto. Md.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Univ. of Md. Hospital. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>none   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>none    |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |                                     | 13e. STREET ADDRESS<br>1006 SPANGLER WAY.    |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>DANIEL D. MEYERS   |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>RUTH A. HAUGHT. |   |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>-   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>-                                |   | 17 INFORMANT ADDRESS<br>from chart. |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u><br><u>7580</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Open Repair of Ventricular Septal Defect</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Mongolism with multiple Congenital Heart anomaly</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br>10/17/80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Septal defect.   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/16</u> 19 <u>80</u> to <u>10/17</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/17</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |                                     |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br>10/17/80  |                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>YO-Jun Song, M.D.   |  |  |  | 22e. ADDRESS<br>Univ. of Md. Hospital at Balto.  |  |   |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/20/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto. Md.   |                                     |  |
| 24 FUNERAL HOME<br>S. Brehms Funeral Home, Inc.  |  |  |  | 25. DATE REC'D BY REGISTRAR<br>00141 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |                                     |  |



Handwritten signature or mark.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

|  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| Item #185 per phone call w/Fun.<br>FOR<br>1- STATE Home 10/21/80 rc<br>REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 5 6 9 0<br>REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>(AKA Alfred J. Matejka) Michael<br>ALFRED J. MICHAEL  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-17-80   |  |   |  | 2b. HOUR<br>8:25pm  |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 25, 1904   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>B.G.&E.  |  |  |  |
| 13a. STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2828 Ashland Ave., 21205  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anthony - Michael  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth - Strejcek   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No -   |  |  |  | 16b. SOCIAL SECURITY NO.<br>212-05-6041   |  | 17. INFORMANT<br>ADDRESS<br>3614 Bellevue Ave.<br>Eileen E. Simpson, dgtr., 21206 |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>AORTIC REGURGITATION</u><br>7241<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CONGESTIVE HEART FAILURE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>xxx 10-13-</u> 19 <u>80</u> , to <u>xx 10-17-</u> 19 <u>80</u> , that (1) (we) lost <u>now</u> the deceased on <u>10-17-80</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.                 |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  |   |  | 22c. DATE SIGNED<br>10/17/80  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. IMPAGLIATELLI WALKER  |  |  |  |   |  |   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY <del>xxx</del> BALTIMORE, MD 31  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/21/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer Baltimore Md.  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.   |  |  |  | 24b. ADDRESS<br>3331 Brehms Lane Balto., Md. 21213  |  |   |  | 24c. DATE RECD. BY REGISTRAR<br>OCT 21 1980   |  |  |  |

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TO HOSPITAL C. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

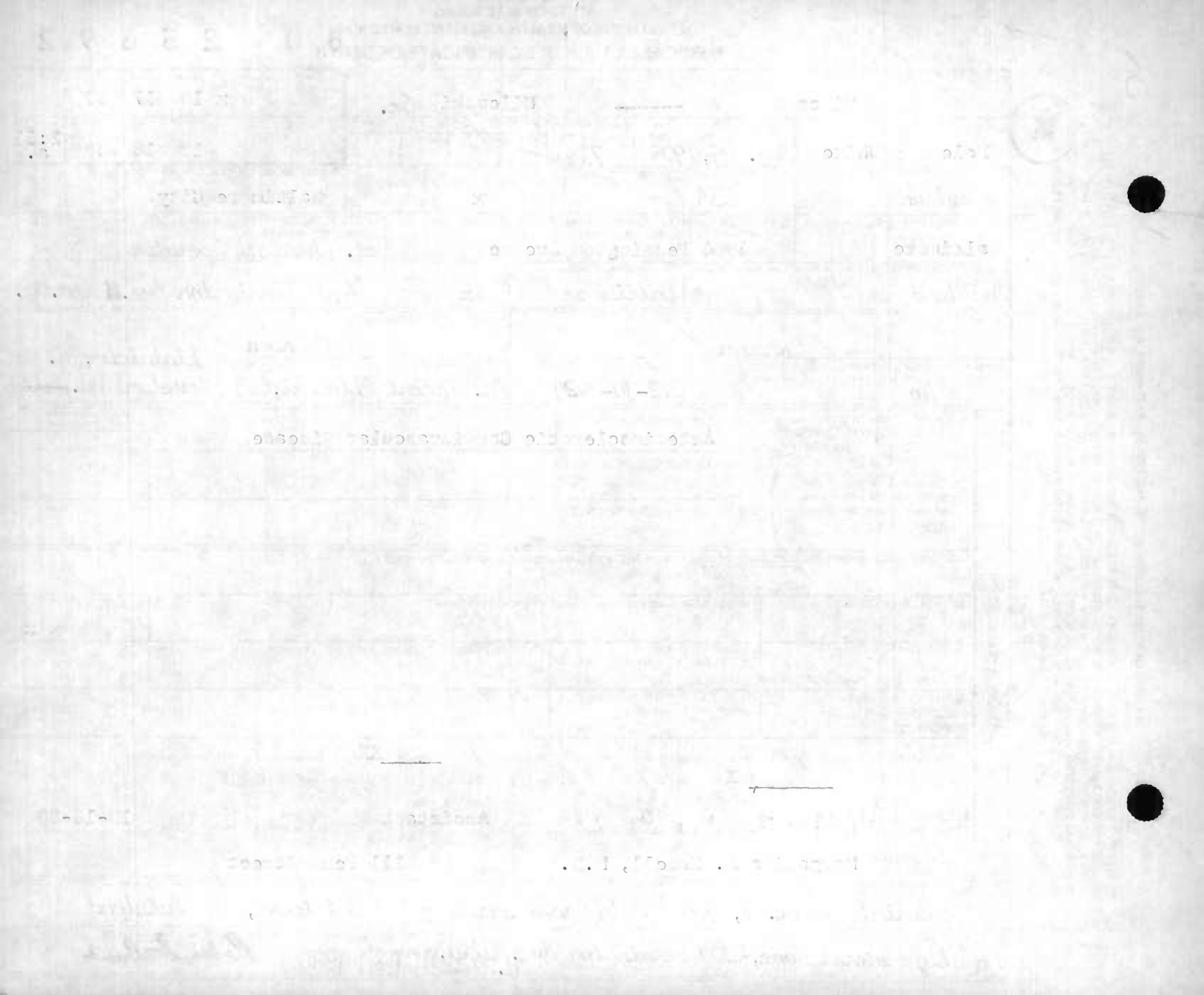
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  | 8 0 2 5 6 9 1  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Justine V. Middleton</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 7, 1980</b>             |  | 2b. HOUR<br><b>4:43P M</b>   |  |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 5 06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b>                              |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>515 N. Arlington Ave.</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jack Middleton</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy Middleton</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-05-1353A</b>   |  | 17. INFORMANT ADDRESS<br><b>Anna Belle Martin 3144 N. Achilles S</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>Renal Failure</b><br>IMMEDIATE CAUSE (a)<br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10/5/80</b><br><b>10/5/80</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Adult Respiratory Distress Syndrome, Carcinoma of Stomach</b>   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>9/18/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 10, 19 80</b> , to <b>October 7, 19 80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>October 7, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>D. MacPherson</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/7/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas MacPherson, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/15/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>         |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>   |  | 25b. SIGNATURE<br><b>Patricia K. [Signature]</b>                          |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |   |   |  |   |  |  |   | REG. NO. 80 25692   |  |
|---|--|-------------------------|---|---|--|---|--|--|---|---|--|
| 1- FOR STATE REGISTRAR  |  |                         | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Vincent Milewski Sr.</b>   |   |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 10 17 80              |  |   | 2b. HOUR<br>M 2:31 a.m.   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Aug. 25, 1905</b>           |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75 YRS.</b>   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>10 18 80</b>               |   | 2d. HOUR<br>M 2:31 a.m.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4904 Pennington Avenue</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Chemical Operator</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         | 13b. COUNTY<br><b>Baltimore</b>   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET ADDRESS<br><b>4904 Pennington Ave. Balto. Md.</b>     |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |                         |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown Linthicum, Md.</b>  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>212-30-2409</b>                    |  | 17. INFORMANT ADDRESS<br><b>Mr. Vincent Milewski, 625 Cleveland Rd. Balto</b>   |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>Arteriosclerotic Cardiovascular Disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                         |   |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |   |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |   |   |  |   |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Deopite Bekehl</b>   |  |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>                               |  |   |  | DATE SIGNED<br><b>10-18-80</b>   |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  |                         |   | ADDRESS<br><b>111 Penn Street</b>                                 |  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |   | 23b. DATE<br><b>Oct. 21, 1980</b>                                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home, 4200 Pennington Ave. Balto. Md. 21226</b>  |  |                         |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>P. H. H. H.</b>                         |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |   | 8 0 2 5 6 9 3                                |  |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.   |  |  |   |  |  |   |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>MARIE J.  |  |  | MIDDLE<br>MILLER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 11 80   |  |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-6-21   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospitals                |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>928 Roman Way                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Peter Moore  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |  | 16b. SOCIAL SECURITY NO.<br>212168429   |  |  | 17. INFORMANT<br>ADDRESS<br>Florence H. Manley 8255 Bellhaven Rd.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CHRONIC OBSTR. LUNG DISEASE<br>492-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) (EMPHYSEMA)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br>None   |  |  |  |  |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 77 to Oct 11 19 80, that (I) (we) last saw the deceased alive on Aug 29 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Edward James Britt   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>10/11/80  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD JAMES BRITT  |  |  | 22e. ADDRESS<br>6000 SAINT RITAN HOSPITAL BALTIMORE  |  |  |   |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>10-14-80  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAKHURST CEMETERY   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Philip E. Green  |  |  | ADDRESS<br>1211 Chesebrough Ave.   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Ruth H. Green   |  |  |  |  |

WINTER 1911

WINTER 1911

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(19R A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80 25694

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE KNOWN OF DEATH  |   | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | 2c. DATE ESTIMATED   |   | 2d. HOUR  |  |
| Morgan Hassel Miller   |   | 10 17 1980   |   | M   |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS.                             |
| Male   | White   | Feb. 19, 1928  | 52 YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Virginia   | U.S.A.  |  |   | Baltimore City, MD.   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore  | John Deaton Medical Center  | Electrician  |   | Electrical  |  |
| 13a. STATE   |   | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?  | 13d. STREET ADDRESS   | 13e. CITY OR TOWN                            |
| Maryland   | Anne Arundel  | Pasadena   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 765 204th St.   | 21122  |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME   |   |   |  |
| Mont C. Miller   |   | Mary E. Hess   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |   |  |
| Yes  |   | 230-30-0715  | Georgia E. Miller Same as #13                                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:  |   |  |   |   |  |
| IMMEDIATE CAUSE (a) Traumatic injuries with  |   |  |   |   |  |
| 9291   |   |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |   |  |   |   |  |
| (b)  |   |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |   |  |   |   |  |
| (c)  |   |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?  |  |
|  |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
|  |   | P.M. 10 11 19 75   |   | Airplane crash  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION   |  |
|  |   |  |   | CITY OR TOWN COUNTY STATE   |  |
|  |   |  |   | Hampton VA.   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |   |  |   |   |  |
| ACTUAL SIGNATURE   |   | TITLE (SPECIFY)  |   | DATE SIGNED   |  |
| Thomas D. Smith, M.D.  |   | Deputy Chief   |   | 10/17/80  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |   | ADDRESS  |   |   |  |
|  |   | 111 Penn St. Balto., MD.   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY                                  | 23d. LOCATION   |  |
| Burial   |   | 10/20/1980   | Glen Haven Mem. Park  | Glen Burnie, Anne Arundel, Md.  |  |
| 24. FUNERAL DIRECTOR NAME  |   | 24b. ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR   |  |
| Mc Cully F.H. Mtn. & Tick Neck Rds., Pasadena, Md.   |   | 21122  |   | OCT 21 1980   |  |

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |   |  |   |   |   |                                   |  |  |
|--|-------------------------|---|--|---|---|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Loretta Mills</b>  |                         |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>10 20 19 80</b>   |   |   |                                   | 2b. HOUR<br><b>M</b>                         |  |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 5 37</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>43</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br><b>10 20 19 80</b>                | 2d. HOUR<br><b>6:26A</b>  |                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>4 S. Woodington Rd.</b>                                   |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sidney McKnight</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edna Mil ler</b>  |  |   |   |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>212-32-6287</b>  |  | 17. INFORMANT ADDRESS<br><b>Charles Mills 2532 Quantico</b>   |   |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |  |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |   |   |                                   |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |                                   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |   |                                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |   |                                   |  |  |
| ACTUAL SIGNATURE<br><b>H. R. Guard</b>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |   | DATE SIGNED<br><b>10/20/80</b>  |                                   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>   |  |   |   |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>10/25/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>               |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia K. Bundy</b>                              |                                   |  |  |

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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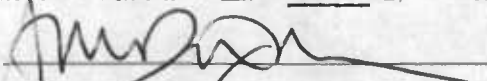

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |  |   |  |   |   |   | REG. NO. 25696 |  |
|--|-------------------------|---|--|--|---|--|---|---|---|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KELLY DEE MILWEE</b>  |                         |   |  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 8 1980</b> |   | 2b. HOUR <b>5:20 P</b>  |   |                |  |
| 3. SEX<br><b>female</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>(MONTH DAY YEAR) <b>4/2/77</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>3</b> YRS.                                  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>10 8 1980</b>  |   | 2d. HOUR <b>5:20 P</b>  |   |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |   |   |   |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>                             |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |                |  |
| 13a. STATE<br><b>MD.</b>   |                         |   |  |  |   | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>MIDDLE RIVER</b>  |   |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ROBERT MILWEE</b>   |                         |   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DOLORES BURKMAN</b>                                  |   |   |   |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT<br><b>PARENTS</b>   |  | 17. ADDRESS<br><b>ABOVE</b>                         |   |   |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>8147 Cranio-cerebral injury</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |  |   |  |   |   |   |                |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                              |  |   |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>4:20 P.M. 10-8-1980</b>       |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Pedestrian struck by motor vehicle.</b> |  |   |   |   |                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>driveway</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>12308 Eastern Ave. Balto. Md.</b>                                   |  |   |   |   |                |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |   |  |  |   |  |   |   |   |                |  |
| ACTUAL SIGNATURE<br>  |                         |   | M.D. <b>Assistant</b>  |  |   | MEDICAL EXAMINER   |   |   | DATE SIGNED <b>10-9-80</b>  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |                         |   | ADDRESS<br><b>111 Penn St.</b>   |  |   |  |   |   |   |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         |   | 23b. DATE<br><b>10/11/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILL</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO MD.</b>                      |   |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>   |                         |   |  |  | ADDRESS<br><b>300 MACE</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b> |   | 25b. REGISTRAR'S SIGNATURE<br> |                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 0 2 5 6 9 7<br>REG. NO.  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>KATHRYN C. MINCHER  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 7, 1980                                  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>March 20, 1929                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Floor-Lady  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bakery  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>-   |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John - Hulihan  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Edna - Delseit  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-24-0746   |  | 17. INFORMANT ADDRESS<br>James Mincher 813 S. Montford Ave.                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>2506<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>ESCHERICHIA COLI SEPSIS<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>DIABETES MELLITUS |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>RENAL FAILURE; RESPIRATORY FAILURE; UPPER GASTROINTESTINAL BLEEDING  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>9-30-80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>GANGRENOUS LEFT FOOT; DIABETIC VASCULAR DISEASE                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from AUGUST 28, 19 80, to OCTOBER 7, 19 80, that (I) (we) lost saw the deceased alive on OCTOBER 7, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br>Tahoorah Khwaja M.D.  |  |  |  | 22c. DATE SIGNED<br>10-10-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>TAHOORA KHWAJA   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 N. BROADWAY, BALTIMORE, MD 21231  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Oct. 10, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OakLawn Cemetery                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>- - Baltimore, Maryland   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lilly & Zeiler Inc. 1901 Eastern Ave./21231  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 9 1980  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. McCreedy   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                         |  |  |   |   |   |   |
|---|-------------------------|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Cliffmth R. Montgomery</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH 10 DAY 7 YEAR 1980 |   |   | 2b. HOUR<br>M 5:10 P 10   |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH 11 DAY 13 YEAR 1917  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY 62 YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH 10 DAY 7 YEAR 1980                                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kayford, W. Va.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fork Lifter</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Paint Co.</b> |
| 13a. STATE<br><b>Md.</b>  |                         | 13b. COUNTY<br><b>A.A. Co.</b>   | 13c. CITY OR TOWN<br><b>Pasadena</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS<br><b>8320 Ritchie Hwy.</b>                                     |   |   |
| 14. FATHER'S NAME<br>FIRST LAST<br><b>Clyde Montgomery</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Griffith</b>                                |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>225-05-7985</b>   |  | 17. INFORMANT ADDRESS<br><b>Wilda C. Montgomery above</b>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Head and Neck Injury</b><br>8/50<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                         |  |  |   |   |   |   |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR 5:06 P.M. MONTH 10 DAY 6 YEAR 1980   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Driver of auto/fixed object impacts</b>                                 |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Rt. 2 Anne Arundel, Md.</b>   |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .  |                         |  |  |   |   |   |   |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>  |                         | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |   | DATE SIGNED<br><b>10/8/80</b>   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |                         | ADDRESS<br><b>111 Penn Street</b>  |  |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>10-10-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey Howard Md.</b>              |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Barranco Funeral Home-Severna Pk., Md.</b>   |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony A. ...</i>                                 |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 6 9 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES A. MONTGOMERY   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 17, 1980 |   |  | 2b. HOUR<br>6:35 P.M.  |  |
| 3. SEX<br>male   |  | 4. RACE<br>Col.  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-26-1898   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |   |   |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Balt.   |   | 13c. CITY OR TOWN<br>Balt.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew Montgomery  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Cochran   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>217-07-2480  |  | 17. INFORMANT<br>Address<br>Marilyn Taylor 2314 Lyndhurst Ave.   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MZMSTATIC GASOLIC CA<br>1519<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YEARS |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br>10/9/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Common duct obstruction  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/5/80, 19_____, to 10/17/80, 19_____, that (I) (we) lost<br>saw the deceased alive on 10/17/80, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I here) (do) (did not) view the body after death.   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Robert J. Davis  |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>10/17/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVIS   |  | 22e. ADDRESS<br>UNION MEMORIAL HOSP  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10-24-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westport   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ   |  | ADDRESS<br>2222 W. North Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |   |   |                               |  |  |  |  | REG. NO. 8 0 2 5 7 0 0 |  |
|---|-------------------------|--|---|---|-------------------------------|--|--|--|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Luther R. Moore</b>  |                         |  |   |   |                               | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> MONTH DAY YEAR <b>10 6 19 80</b> |  | 2b. HOUR <b>5:58 P M</b>   |  |                        |  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3-20-18</b>  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>62</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>10 6 19 80</b>   |  | 7d. HOUR <b>5:58 P M</b>   |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hosp.</b> |   |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Security Guard</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY   |                         |  |   |   |                               | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Richard F. Moore</b>  |                         |  |   |   |                               | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Rosa Duncan</b>   |  |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>W.W. II 248 01 1385</b>   |   | 17. INFORMANT ADDRESS<br><b>Lessie Sheppard Balto 21225 5418 Wasena Ave.</b>  |                               |  |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b> IMMEDIATE CAUSE (a) <b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |                         |  |   |   |                               |  |  |  |  |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |   |   |                               |  |  |  |  |                        |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                               |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |                        |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |  |  |  |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |  |  |  |  |                        |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |   |                               |  |  |  |  |                        |  |
| ACTUAL SIGNATURE<br><b>Thomas D. Smith</b>  |                         | TITLE (SPECIFY)<br><b>Deputy Chief</b>   |   |   |                               | DATE SIGNED<br><b>10-7-80</b>  |  |  |  |                        |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St.</b>   |   |   |                               |  |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>10/9/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brooklyn A.A. Md.</b>   |  |  |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonc</b>   |                         | ADDRESS<br><b>4001 Ritchie Hgwy.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1980</b>   |                               | 25b. REGISTRAR'S SIGNATURE<br><b>History McBrady</b>   |  |  |  |                        |  |

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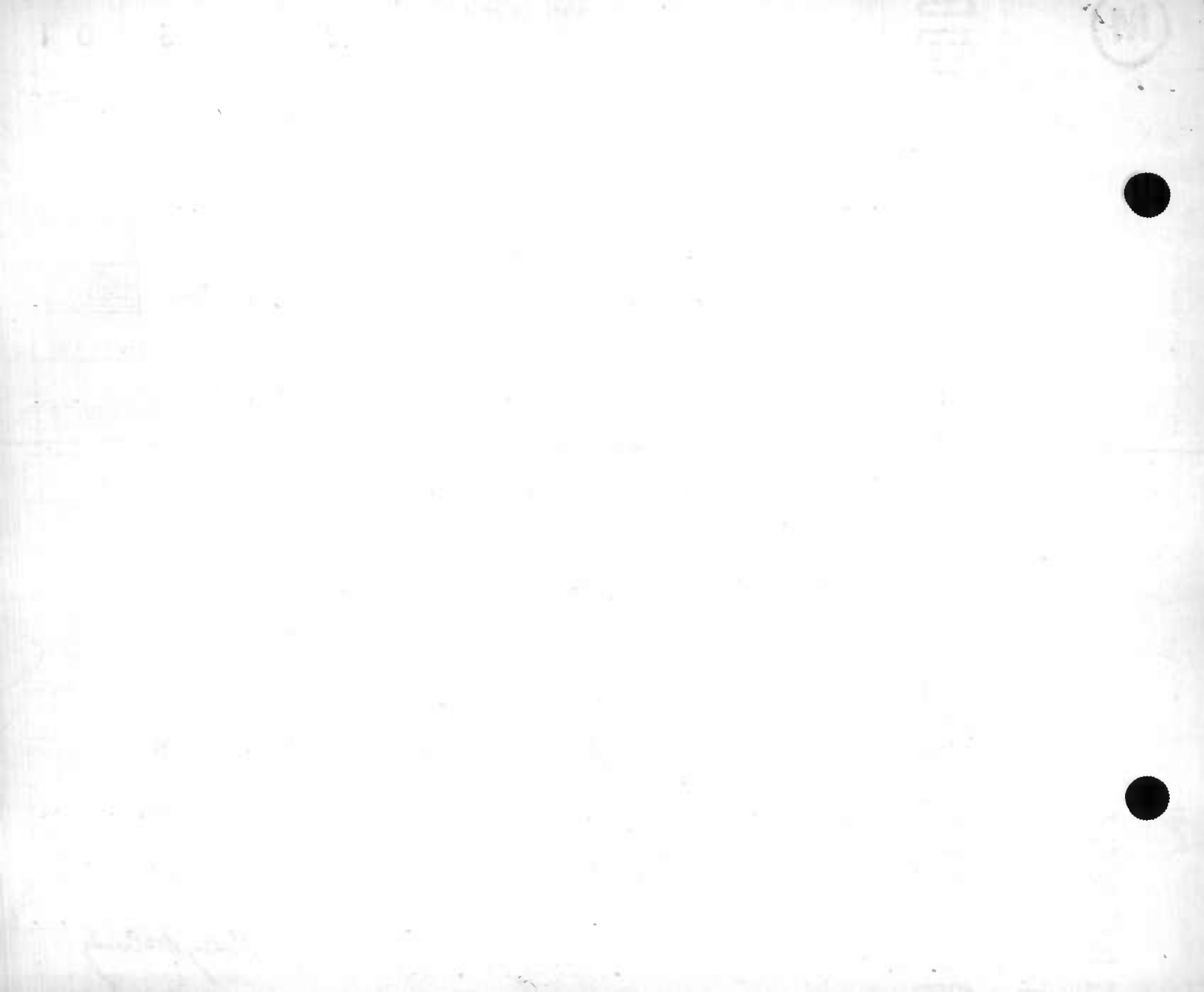
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |  |   |  |          | 8025701  |  |
|---|--|--|---|---|--|--|---|--|----------|--|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.  |   |  | 2a. DATE OF DEATH  |   |  | 2b. HOUR |  |  |
| DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ROSA MOORE  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 31, 1980                |   |  | 2b. HOUR<br>7:47 AM  |   |  |          |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 27 06  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |          | 8. IF UNDER 24 HRS<br>HOURS MIN                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |          |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4136 W. Forest Park Avenue |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |          |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |   |  |  |   |  |          |  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br>4136 W. Forest Park Ave.  |          |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Ellis   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Louisia Norville  |  |  |   |  |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>245-72-5085  |   | 17. INFORMANT ADDRESS<br>Sudie Woodard 4136 Forest Park Ave.  |  |  |   |  |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal Failure</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diabetes Mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension, Peripheral Vascular Disease</u>   |  |  |   |   |  |  |   |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 yrs<br>20 yrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |   |  |          |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |          |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |          |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>80</u> , to <u>Oct 31</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Oct 10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |  |          |  |  |
| 22b. SIGNATURE<br>Barton K. Hershfield MD   |  |  |   |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>10-31-80   |          |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Barton K. Hershfield   |  |  |   |   |  | 22e. ADDRESS<br>Family Health Ctr. Univ Md Hosp  |   |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>11/5/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Delight Cem. |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Walstonburg N.C. |  |          |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March F/H   |  |  |   |   |  | ADDRESS<br>1101 E. North Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1980  |          | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                        |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 6 5 4 5 5 6 9 0 2

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY E. MOSELEY</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>OCT</b> DAY <b>4</b> YEAR <b>1980</b>    |   |  | 2b. HOUR<br>M <b></b>  |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>MARCH</b> DAY <b>8</b> YEAR <b>1883</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>97</b>   |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti City</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balti.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>923 Rutland Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>md.</b>   |  |  | 13b. COUNTY<br><b>Balti.</b>   |   | 13c. CITY OR TOWN<br><b>Balti.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Harward</b> MIDDLE <b>Jackson</b> LAST <b></b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Cordelia</b> MIDDLE <b></b> LAST <b></b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-44-4887</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>MARY Lucas 923 Rutland Ave.</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4149</b><br>IMMEDIATE CAUSE (a) <b>Unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary artery disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>Congestive heart failure</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sym 1 year</b> |  |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/15</b> , 19 <b>75</b> , to <b>10/4</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>5/16/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>F. E. Munschauer</b> M.D.   |  |  | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Oct 7 '80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F. E. MUNSCHAUER</b>   |  |  | 22e. ADDRESS<br><b>601 N. BROADWAY</b>                                 |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>OCT. 7, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbiter's Kn. Ac.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Balti.</b> COUNTY <b>md.</b> STATE <b></b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loche Funeral Home</b> ADDRESS <b>13047 Central</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 8 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |  |

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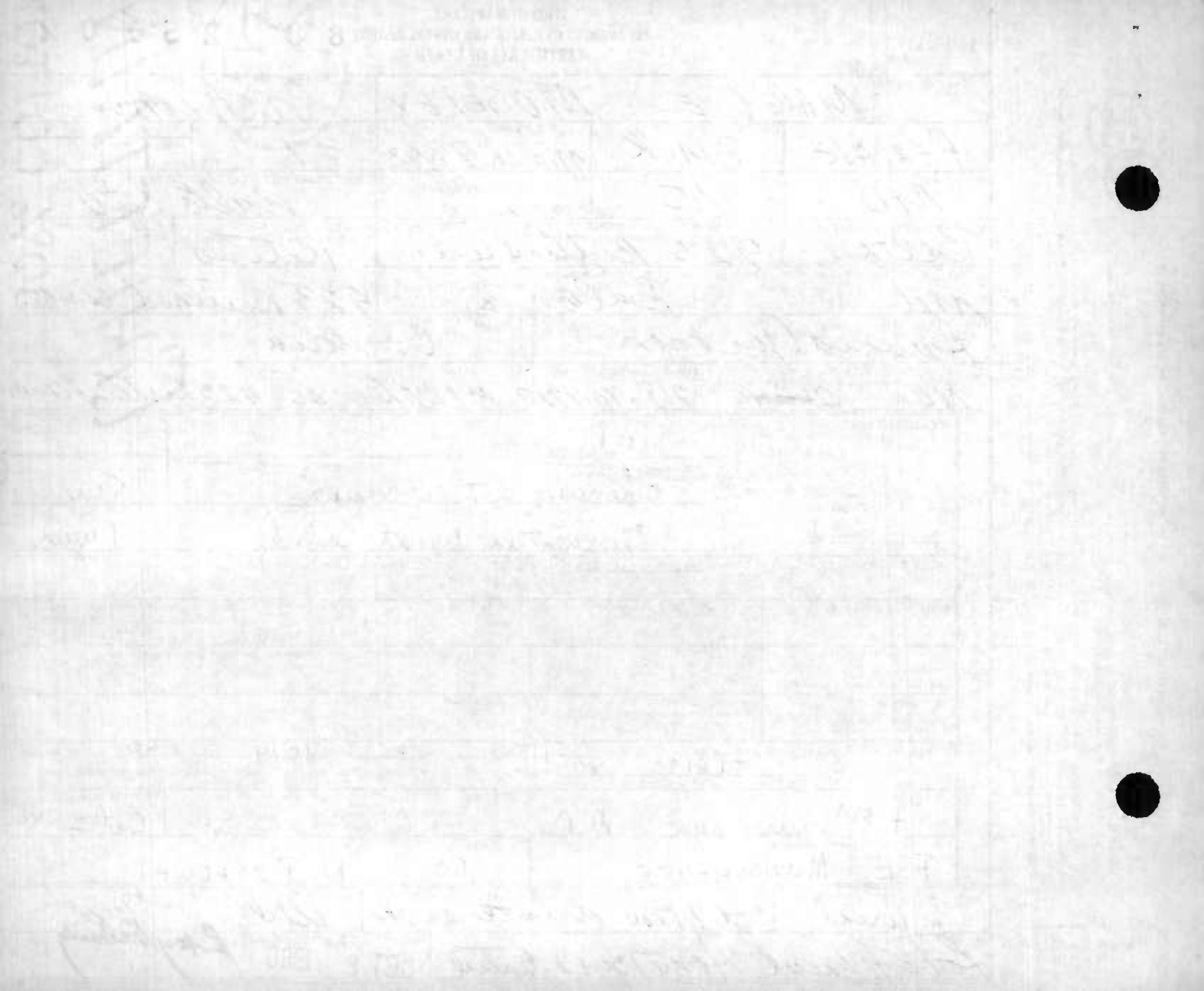
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |   |   |  |  |  |
|--|--|---|--|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BLANCHE MORGAN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 16 80</b>                   |   |   | 2b. HOUR<br><b>12:00 PM</b>                                       |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUC.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 09 85</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS                  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Federal Hill No. 1013 Light St.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MD</b> |  |   | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>               |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>26 N. Main St.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Zilpha A. Morgan</b> |   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>          |  |   | 16b. SOCIAL SECURITY NO<br><b>217-26-3141A</b>                           |   | 17. INFORMANT<br>ADDRESS<br><b>Federal Hill N/H</b> |   |   |  |  |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Atherosclerotic Heart Disease</b><br>(c) <b>Due to, or as a consequence of</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
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## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> , 19 <b>80</b> , to <b>10-16</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10-16</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Marsha Brown</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10-17-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marsha Brown</b>  |  |  |  | 22e. ADDRESS<br><b>844 N. Cary St.</b>   |  |  |  |

|  |  |                              |  |   |  |   |  |
|--|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                         |  | 23b. DATE<br><b>10/22/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b> |  |                              |  | 25a. DATE RECD. BY REGISTRAR<br><b>OCT 22 1980</b>            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Harty</b>                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. 22103

March 10, 1964

Dear Sir:

Enclosed

is a copy

of the report

on the subject of

the proposed

amendment to

the existing

regulations

governing the

operation of

the various

departments

of the

Government

and the

various

agencies

concerned

Very truly yours,

W. H. R.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                              |  |  |                                    |  |   |  |                                   | 8 0 2 5 7 0 4                                |                 |  |
|---|--|------------------------------|--|--|------------------------------------|--|---|--|-----------------------------------|--|-----------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |                              | CERTIFICATE OF DEATH   |  |                                    |  |   |  |                                   | REG. NO.                                     |                 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST MIDDLE LAST  |  |                                    | 2a. DATE OF DEATH  |   |  | MONTH DAY YEAR                    |  | 2b. HOUR        |  |
| AMANDA S. MORRIS  |  |                              |  |  |                                    | OCT. 4, 1980   |   |  |                                   |  | 12:45 AM        |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                   |  | IF UNDER 72 HRS |  |
| FEMALE  |  | WHITE                        |  | MAY 22, 1964   |                                    |  | 16  |  | MONTHS DAYS                       |  | HOURS MIN       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |  |                 |  |
| TENNESSEE   |  | USA                          |  |  |                                    |  | BALTIMORE CITY MD.  |  |                                   |  |                 |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                 |  |
| BALTIMORE   |  |                              | JOHNS HOPKINS HOSPITAL   |  |                                    | STUDENT  |   |  | SCHOOL                            |  |                 |  |
| 13a. STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS               |  |                 |  |
| MARYLAND  |  |                              |  |  | BALTIMORE                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2204 SOUTH RD. (21209)            |  |                 |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |   |  |                                   |  |                 |  |
| ALAN  |  |                              | MORRIS   |  |                                    | SALLY  |   |  | ABEL                              |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT  |   |  | ADDRESS                           |  |                 |  |
| NO  |  |                              |  |  |                                    | MRS. SALLY NEUSTADT  |   |  | 2204 SOUTH RD. (21209)            |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |                                    |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                 |  |
| PART I. DEATH WAS CAUSED BY:  |  |                              |  |  |                                    |  |   |  |                                   |  |                 |  |
| IMMEDIATE CAUSE (a) <u>Respiratory and Cardiac Failure</u>  |  |                              |  |  |                                    |  |   |  |                                   |  |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |                                    |  |   |  |                                   |  |                 |  |
| (b) <u>Unrel Humiliation</u>  |  |                              |  |  |                                    |  |   |  |                                   | 24 hr.                                       |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |  |                                    |  |   |  |                                   |  |                 |  |
| (c) <u>OPTIC NERVE GLIOMA</u>   |  |                              |  |  |                                    |  |   |  |                                   |  |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                              |  |  |                                    |  |   |  |                                   |  |                 |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                    | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |                 |  |
|   |  |                              |  |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY  |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                                   |  |                 |  |
|   |  |                              | HOUR A.M. MONTH DAY YEAR   |  |                                    |  |   |  |                                   |  |                 |  |
|   |  |                              | P.M. 19  |  |                                    |  |   |  |                                   |  |                 |  |
| 21d. INJURY OCCURRED  |  |                              | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |                                    | 21f. LOCATION  |   |  |                                   |  |                 |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |                              |  |  |                                    | STREET CITY OR TOWN COUNTY STATE   |   |  |                                   |  |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>09/23</u> , 19 <u>80</u> , to <u>10/04</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/04</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |  |   |  |                                   |  |                 |  |
| 22b. SIGNATURE  |  |                              | DEGREE   |  |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED                  |  |                 |  |
| Richard Scott Lemons  |  |                              | MD   |  |                                    |  |   |  | 10-4-80                           |  |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                              | 22e. ADDRESS   |  |                                    |  |   |  |                                   |  |                 |  |
| Richard Scott Lemons  |  |                              | Johns Hopkins Hosp<br>Opt & Radiatn, Baltimore, Md 3   |  |                                    |  |   |  |                                   |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION   |  |                                   |  |                 |  |
| BURIAL  |  |                              | 10-5-80  |  | ARLINGTON CEMETERY                 |  | BALTIMORE MD.   |  |                                   |  |                 |  |
| 24. FUNERAL DIRECTOR NAME   |  |                              | 25. DATE REC'D. BY REGISTRAR   |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |   |  | 25b. DATE REC'D. BY REGISTRAR     |  |                 |  |
| SOL LEVINSON & BROS   |  |                              | BALTIMORE, MD. (21215)   |  |                                    | OCT 8 1980   |   |  | [Signature]                       |  |                 |  |

MEDICAL CERTIFICATION

2

**NAME:** Mary E. Moseley

**DATE OF DEATH:** October 4, 1980

**PLACE OF DEATH:** Baltimore City

**SEE:** #80-25702

**DHMH 2485 - Vit. Rec.**



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

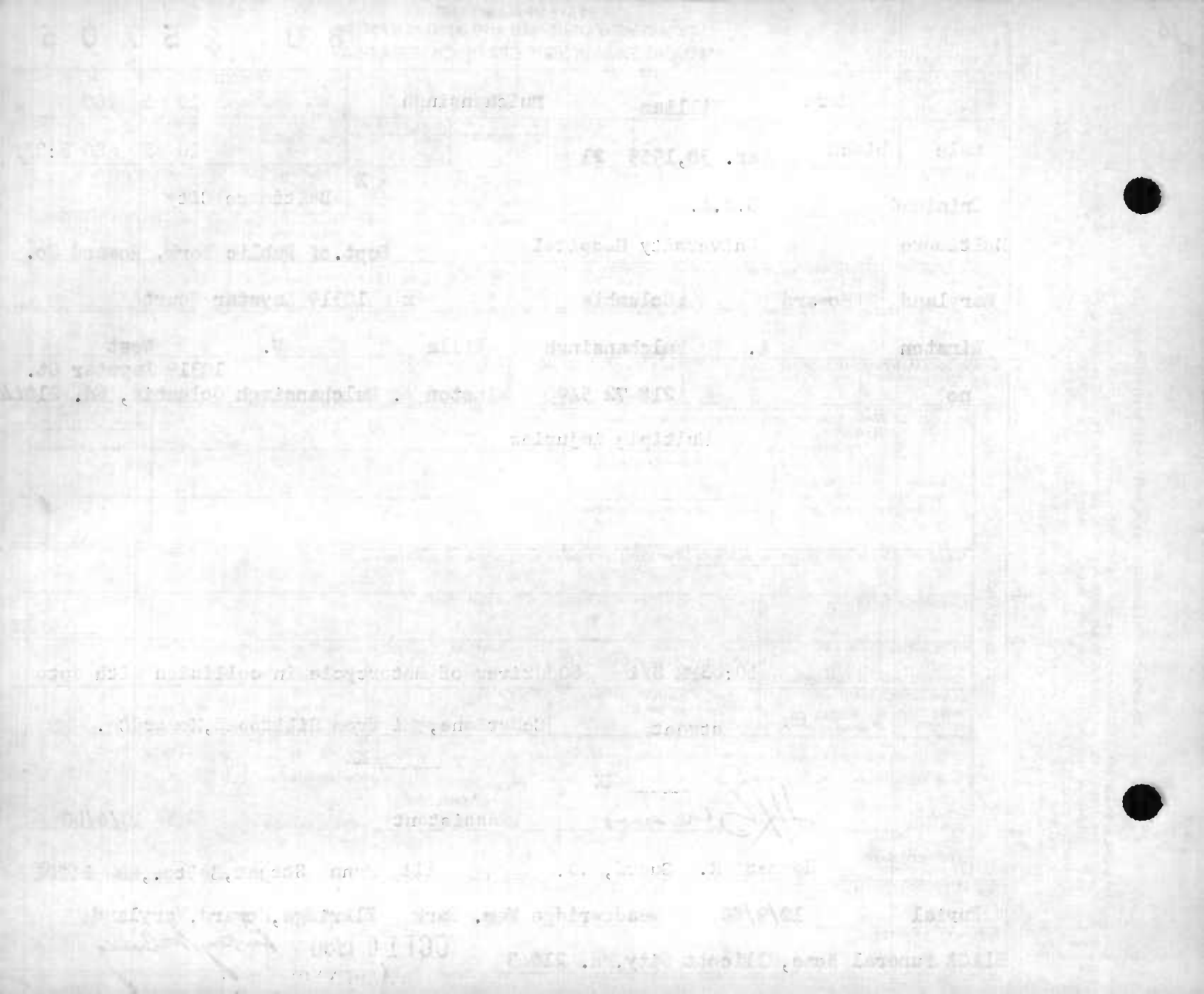
BP

DHM-17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1- FOR STATE REGISTRAR   |  | 2a. DATE KNOWN OF DEATH  |   | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2c. DATE ESTIMATED   |   | 2d. HOUR  |  |
| Mark William Mulchansingh  |  | 10 5 1980  |   | M   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS.                             |
| male   | black  | Mar. 30, 1959  | 21 YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?                             | 8. MARRIED   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| Trinidad   | U.S.A.   | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore  | University Hospital                                      | Dept. of Public Work, Howard Co.   |   |   |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |  |
| Maryland   | Howard   | Columbia   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 10319 Daystar Court   |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME                                 | 16. SOCIAL SECURITY NO.  |   |   |  |
| Winston A. Mulchansingh  | Willa V. West  | 218 72 5490  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   | 16b. SOCIAL SECURITY NO.                                 | 17. INFORMANT  |   |   |  |
| no   | 218 72 5490  | Winston A. Mulchansingh Columbia, Md. 21044  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:  |  |  |   |   |  |
| IMMEDIATE CAUSE (a) Multiple injuries  |  |  |   |   |  |
| 8122   |  |  |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |  |   |   |  |
| (b)  |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |   |  |
| (c)  |  |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   | 20. AUTOPSY?                                 |
|  |  |  |   |   | YES NO <input checked="" type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
|  |  | 10:03 PM 8/1 1980  |   | driver of motorcycle in collision with auto                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION   |  |
|  |  | street   |   | Cedar Lane, 1/2 Mi from Hilltop Rd, Howard Co. MD                             |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |   |   |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)  |   | DATE SIGNED   |  |
| <i>Hormez R. Guard</i>   |  | Assistant  |   | 10/6/80   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS  |   | 22b. DATE   |  |
| Hormez R. Guard, M.D.  |  | 111 Penn Street, Balto., MD  |   | 10/9/80   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. NAME OF CEMETERY OR CREMATORY   |   | 23c. LOCATION   |  |
| Burial   |  | Meadowridge Mem. Park  |   | Elkridge, Howard, Maryland  |  |
| 24. FUNERAL DIRECTOR (NAME AND ADDRESS)  |  |  |   |   |  |
| SLACK Funeral Home, Ellicott City, Md. 21043   |  |  |   |   |  |
| DATE RECEIVED BY REGISTRAR AND REGISTRAR'S SIGNATURE   |  |  |   |   |  |
| OCT 10 1980 <i>Anthony McCreedy</i>  |  |  |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 8 0 2 5 7 0 6  |  |
|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE AND PRINT)<br>FIRST MIDDLE LAST<br><b>MYRTLE ELIZABETH MULLINEAUX</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-27-80</b>                               |  | 2b. HOUR<br>MIN.<br><b>8:50 A</b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 31 1898</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SHELTERED HOME)<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                                      |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>---</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE WILLIAM HAMMOND</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATIE MCCOURT</b>                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO ---</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-5886</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>DONALD HAMMOND MULLINEAUX 37 CAMELLIA DRIVE</b>       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b><br>5770<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Renal Failure, Peritonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hemorrhagic pancreatitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>10-12-80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cholelithiasis, cholangitis, pancreatitis</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>10-12-1980</b> , to <b>10-27-1980</b> , that (I) (we) lost saw the deceased die on <b>10-27-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Lind R. Arguillano</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10-27-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lind R. Arguillano</b>  |  | 22e. ADDRESS<br><b>GBGA</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10/31/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEMETERY</b>                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1980</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME 4107 WILKENS AVE.</b>   |  | 25a. REGISTRAR'S SIGNATURE<br><b>Patricia Maloney</b>   |  |  |  |

002200



*[Faint, illegible handwritten text and markings, possibly bleed-through from the reverse side of the page.]*



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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8025707  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>S. Alfred Mund</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>10/31/80</b>   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 11 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNA. USA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balt city</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>new endale</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ATTORNEY</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT LAW</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>XX XXXX MD</b> 13b. COUNTY <b>XX XXXX BALTIMORE</b> 13c. CITY OR TOWN <b>BALTIMORE</b>  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM MUND</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE LEBELSKY</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-38-0068</b>   |  | 17. INFORMANT <b>MRS. LIBBY MUND</b> ADDRESS <b>6809 CROSS COUNTRY BLVD. #21215</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Septicemia 2° Gangrene/leg days</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of Colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/18</b> 19 <b>77</b> to <b>10/31</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/31</b> 19 <b>80</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b> M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br><b>10/31/80</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NORMAN D. LEST M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>Cross Country Blvd #21215</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>NOV. 2, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SHAAREI TFILOH</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | 80 25708   |  |  |  |
|--|--|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Florence Bell Murray</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>10 17 80</b>   |  |   |  | 2b. HOUR <b>6</b> P.M.   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 10 10</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>                                       |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4129 Hollins Ferry Rd. Balto.</b>                                 |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andy ----- Wampler</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bell ----- Unknown</b>  |  |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>409-07-6466</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Alfreata Salalila, Same as above</b>                        |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>/</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>/</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>SEVERE CHRONIC OBSTRUCTIVE AIRWAYS DISEASE</b>   |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>10/13/80</b> , 19 <b>80</b> , to <b>10/17/80</b> , 19 <b>80</b> , that (he) (we) last saw the deceased alive on <b>10/17/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Abdulk Kuman Chopra</b>   |  |   |  | DEGREE<br><b>M.B.B.S.</b>   |  |   |  | 22c. DATE SIGNED<br><b>10/17/80</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.K. CHO PRA</b>   |  |   |  | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL<br/>900 CATHO AVE. BALTIMORE MD 21229</b>   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Entombment</b>  |  |   |  | 23b. DATE<br><b>Oct. 20, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Glen Burnie Maryland</b> |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Home, 237 E. Patapsco Ave. Balto.</b>   |  |   |  | ADDRESS<br><b>MD. 21225</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harry McHenry</b>  |  |  |  |  |  |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |   |  |   |   |          |
|---|--|---|--|---|--|--|---|--|---|---|----------|
| <div style="text-align: right;">8 0 2 5 7 0 9</div> <div style="text-align: center;">CERTIFICATE OF DEATH</div> <div style="text-align: right;">REG. NO.</div>  |  |   |  |   |  |  |   |  |   |   |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |   | 2a. DATE OF DEATH  |  | MONTH   |  | DAY   | YEAR  | 2b. HOUR |
| FIRST MIDDLE LAST<br>MARIE R MYERS  |  |   |  |   | 10 22 80   |  | 4 <sup>16</sup>   |  | P.M.  |   |          |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR                            |   | IF UNDER 24 HRS                                 |          |
| F   |  | Cau   |  | MONTH DAY YEAR<br>11 15 10  |  | 69 YRS.  |   | MONTHS DAYS                                |   | HOURS MIN.                                      |          |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |   |   |          |
| New York  |  | USA   |  |   |  | Baltimore City MD.   |   |  |   |   |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY          |   |   |          |
| Baltimore   |  | University Hospital   |  |   |  | Housewife  |   |  |   |   |          |
| 13a. STATE  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |   |          |
| MD.   |  |   | PRINCE FRED  |   | Prince   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | RT. 1. - Box 70   |   |          |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME   |   |  |  |   |  |   |   |          |
| FIRST MIDDLE LAST<br>William Robert   |  |   | FIRST MIDDLE LAST<br>MARIE NAT. AMBERG                                 |   |  |  |   |  |   |   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |   | 17. INFORMANT ADDRESS  |  |   |  |   |   |          |
| NO  |  |   | 218-30 2682  |   | Old records Paul G. Myers (same as above)                                      |  |   |  |   |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |  |   |  |   |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |
| IMMEDIATE CAUSE (a) SEPSIS  |  |   |  |   |  |  |   |  |   | 18d.  |          |
| 2028 DUE TO, OR AS A CONSEQUENCE OF<br>(b) LYMPHOMA, CHEMOTHERAPY   |  |   |  |   |  |  |   |  |   | 25d.  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |   |  |  |   |  |   |   |          |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) LYMPHOMA  |  |   |  |   |  |  |   |  |   |   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |   |  |   |   |          |
| O   |  |   |  |   |  |  |   |  |   |   |          |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |          |
| O   |  |   |  |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |   |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |   |          |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/13, 19 80, to 10/22, 19 80, that (1) (we) lost saw the deceased alive on 10/22, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |  |   |   |          |
| 22b. SIGNATURE  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED  |   |          |
| Elizabeth Poplin M  |  |   | M  |   |  |  |   |  | 10/22/80  |   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e. ADDRESS   |   |  |  |   |  |   |   |          |
| Elizabeth Poplin M  |  |   | BCRP 225. Greene St. Baltimore   |   |  |  |   |  |   |   |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |   |          |
| Burial  |  |   | 10/25/1980   |   | Ft. Lincoln Cem.   |  |   | Brentwood Pr. Geo. Md.                     |   |   |          |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   | 24a. DATE REC'D. BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE   |   |  |   |   |          |
| Malley's F.H. Inc   |  |   | Mt. Rainier Md.  |   |  | OCT 28 1980  |   |  |   |   |          |

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



Handwritten notes and diagrams on lined paper. The text is mostly illegible due to fading and bleed-through. Some visible words include "Cotton", "Lemon", "Orange", "Grape", "Apple", "Pear", "Peach", "Plum", "Cherry", "Strawberry", "Raspberry", "Blackberry", "Blueberry", "Huckleberry", "Elderberry", "Gooseberry", "Currant", "Rhubarb", "Kale", "Cauliflower", "Broccoli", "Cabbage", "Spinach", "Lettuce", "Tomato", "Pepper", "Onion", "Garlic", "Potato", "Yam", "Cassava", "Mango", "Pineapple", "Guava", "Lemon-lime", "Pawpaw", "Jackfruit", "Cashew", "Peanut", "Almond", "Walnut", "Pistachio", "Macadamia", "Brazil", "Coconut", "Palm", "Banana", "Plantain", "Custard apple", "Soursop", "Guava", "Lemon-lime", "Pawpaw", "Jackfruit", "Cashew", "Peanut", "Almond", "Walnut", "Pistachio", "Macadamia", "Brazil", "Coconut", "Palm", "Banana", "Plantain", "Custard apple", "Soursop".

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 6 G 548 10/15/80 GB

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |  |  |  |   |  |  |   |  |
|---|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Larry - Nagy  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 / 2 / 80 |   |  | 2b. HOUR<br>5:45 PM  |   |  |
| 3. SEX<br>male  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 26 50  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>28 30 YRS                             |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.               |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baltimore City Hospital |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>-  |  | 13c. CITY OR TOWN<br>Baltimore   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James - Nagy  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Patricia A. / McAllister   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO -  |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-58-7863   |  | 17. INFORMANT<br>ADDRESS<br>Patricia Nagy 49 Midway Dr./McKeesrocks, Pa. |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary arrest<br>2500 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) Diabetes - juvenile onset<br>gave rise to immediate }<br>cause (a), stating the } DUE TO, OR AS A CONSEQUENCE OF<br>underlying cause last } (c) (R) sided cerebral infarct |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/1/19 80, to 10/2/19 80, that (I) (we) lost<br>saw the deceased alive on 10/2/19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br>Susan Runge   |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>10/2/80  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Susan Runge  |  |  |  | 22e. ADDRESS<br>Baltimore City Hospitals  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>Oct. 3, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore - Maryland       |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lilly & Zeiler Inc. 1901 Eastern Ave.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 3 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McNeely                            |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |   |  |
|---|--|--|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 8 0 2 5 7 1 1<br>REG. NO.  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>FRIEDA G. NATHAN</u>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <u>10</u> DAY <u>07</u> YEAR <u>80</u> 2b. HOUR <u>10:00 PM</u> |  |  |  |   |  |
| 3. SEX<br><u>FEMALE</u>   |  | 4. RACE<br><u>CAUCASIAN</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>02</u> DAY <u>02</u> YEAR <u>06</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>74</u> YRS.                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN. <u>  </u> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>U.S.A.-N.Y.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City MD</u>                   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>UNIVERSITY OF MARYLAND HOSP.</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>RETIRED</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>SECTY</u>                                    |   |  |
| 13a. STATE<br><u>MARYLAND</u>   |  |  |  |   | 13b. CITY OR TOWN<br><u>COLUMBIA</u>   |  | 13c. STREET ADDRESS<br><u>9348 RUSTLING LEAF Rd</u>                                  |  |   |  |
| 14. FATHER'S NAME<br>FIRST <u>HYMAN</u> MIDDLE <u>  </u> LAST <u>GANG</u>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>MOLLIE</u> MIDDLE <u>  </u> LAST <u>DEITEL</u>        |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>NO</u>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><u>579-42-9605</u>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widely Metastatic Carcinoma of the Colon</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u>  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1539</u>                                |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>Hepatic dysfunction due to metastasis</u>  |  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>  </u> <u>  </u> <u>19</u>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 7, 1980</u> to <u>October 7, 1980</u> , that (I) (we) lost <u>  </u> saw the deceased alive on <u>  </u> 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. |  |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Stuart J. Tipping M.D.</u>   |  |  |  |   | DEGREE<br><u>  </u>  |  |  | 22c. DATE SIGNED<br><u>10-7-80</u>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>STUART J. TIPPING, M.D.</u>   |  |  |  |   | 22e. ADDRESS<br><u>22 South GREENE STREET BALT Md.</u>                                     |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF) <u>Burial</u>   |  |  |  |   | 23b. DATE<br><u>Oct 10 1980</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>King David</u>                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Falls Church Fairfax VA</u>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>CHAMBERS</u> ADDRESS <u>Georgia Ave. Silver Spring Md.</u>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 14 1980</u>  |  | 25b. REGISTERED SIGNATURE<br><u>  </u>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 1 2

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELSIE L. NEAL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/23/80</b>                                |  | 2b. HOUR<br><b>3:45am</b>  |
| 3 SEX<br><b>Female</b>  | 4. RACE<br><b>Negro</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-22-1924</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House-Wife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Charles</b>   | 13c. CITY OR TOWN<br><b>Hughesville</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Woodland</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Plater</b>                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-52-3723</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Rt. 1-Box 17</b><br><b>Edith Ford Christ Ch. Rd. Aquasco, Md.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>myocardial ischemia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>hypertension, diabetes, thyroid d.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10-75 min</b><br><b>uncertain</b><br><b>years</b> |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>10/14</b> , 19 <b>80</b> , to <b>10/23</b> , 19 <b>80</b> , that (we) last saw the deceased alive on <b>3:45pm 10/23</b> , 19 <b>80</b> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>R Edwards</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>10/23/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R Edwards</b>   |  | 22e. ADDRESS<br><b>John Hopkins Hospital</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/27/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary Ch. Cem. Bryantown Chas. Md.</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Martell Adams</b>  |  | ADDRESS<br><b>Aquasco, Md. 20608</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1980</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's office must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |                                   | 8 0 2 5 7 1 3<br>REG. NO.          |  |
|--|--|---|--|--|--|--|--|--|-----------------------------------|------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | I. DECEASED NAME (TYPE OR PRINT)<br>Julian Spencer Neal   |  |  |  | 2a. DATE OF DEATH<br>October 5, 1980   |  |  | 2b. HOUR<br>7:30a M               |                                    |  |
| 3 SEX<br>male  |  | 4 RACE<br>white   |  | 5 DATE OF BIRTH<br>July 15, 1909   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS   |                                   | 8 IF UNDER 24 HRS<br>HOURS MIN     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |                                   |                                    |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>105 Churchwardens Road |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chrm.of Bd.-Fidelity & Deposit |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                                    |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET ADDRESS<br>105 Churchwardens Road  |                                   |                                    |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lonnie Neal   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie Gilley   |  |  |  |  |                                   |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>340-07-7377  |  | 17 INFORMANT ADDRESS<br>Mrs. Harriet Neal 105 Churchwardens Rd.                                    |  |  |                                   |                                    |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of colon with metastases</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Lines</u><br>(c) <u>Due to, or as a consequence of</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mos</u> |  |   |  |  |  |  |  |  |                                   |                                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |                                   |                                    |  |
| 19a. DATE OF OPERATION<br><u>May 19 80</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Carcinoma of colon</u>   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |                                   |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |                                   |                                    |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |                                   |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 19 65</u> , to <u>Oct 5 19 80</u> , that (I) (we) last saw the deceased alive on <u>Oct 4 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |                                   |                                    |  |
| 22b. SIGNATURE<br><u>Franklin E. Leslie</u>  |  |   |  | DEGREE<br><u>MD</u>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br><u>10-5-80</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Franklin Leslie   |  |   |  | 22e. ADDRESS<br><u>3501 48 Ave NE Balto Md. 21218</u>  |  |  |  |  |                                   |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>   |  | 23b. DATE<br><u>Oct. 5, 1980</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedarwood Cemetery</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Roanoke Rapids, Halifax Co., N.C.</u>             |  |  |                                   |                                    |  |
| 24 FUNERAL DIRECTOR<br>Name <u>Mitchell-Wiedefeld Home</u> ADDRESS <u>6500 York Rd. Bal. Md.</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 14 1980</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert M. Brady</u>   |  |  |                                   |                                    |  |



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Oct. 7, 1908  
Cedarwood Cemetery  
Lansing, Mich.  
M.C.

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Cedarwood Cemetery  
Lansing, Mich.  
M.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |  | REG. NO.<br>80 25714                         |  |
|---|--|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>MELVIN NEAL   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 11, 1980 |   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 26 07   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>609 N. Ashburton St. |  |   |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>609 N. Ashburton St.  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-05-6778  |   | 17. INFORMANT<br>ADDRESS<br>Bernice Neal 609 N. Ashburton St.                                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u><br>5070<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEIZURE DISORDER</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/80</u> , 19 <u>80</u> , to <u>10/80</u> , 19 <u>80</u> , that (I/we) lost saw the deceased alive on <u>9/20/80</u> , 19 <u>80</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did not) view the body after death.                      |  |   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Edw. L. Schaefer</u>   |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |   |   |  | 22c. DATE SIGNED<br>10/13/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD SCHAEFER  |  |   |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10/16/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD                                  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  |   |  |   |   | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980   |  | SIGNATURE<br><u>Edw. L. Schaefer</u>         |  |

BP

DHMM-16 20M  
(VRA 15, 4) 7/78



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |   |  |   |
|--|---|--|---|
| 1. FOR STATE REGISTRAR   |   | 8025715  |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |   | 2a. DATE KNOWN OF DEATH  |   |
| Audrey Mae Nelson  |   | ESTIMATED MONTH DAY YEAR 10 15 1980  |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   |
| female   | black   | MONTH DAY YEAR 9 4 51  | LAST BIRTHDAY 29 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| MD   | USA   | NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore City MD.  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| BALTIMORE  | 1048 N. Broadway  |  |   |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  |
| MD   |   | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME  | 17. INFORMANT ADDRESS  |   |
| William Graves Jr.   | Mattie Lawrence   | 1343 Patterson P Ave.  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS  |   |
| No   | 218-60-7670   | William & Mattie Graves Jr. Ave.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix with metastasis  |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   | 20. AUTOPSY?   |   |
|  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   | 21f. LOCATION STREET   | CITY OR TOWN COUNTY STATE   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |   |  |   |
| ACTUAL SIGNATURE   | TITLE (SPECIFY)   | DATE SIGNED  |   |
| Hormez R. Guard, M.D.  | Assistant   | 10/15/80   |   |
| EXAMINER'S NAME (TYPE OR PRINT)  | ADDRESS   | 111 Penn Street, Baltimore, MD 21201   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |
| Burial   | 10/18/80  | Mt. Calvary Cem.   | Baltimore Co. MD  |
| 24. FUNERAL DIRECTOR NAME  | ADDRESS   | 25a. DATE REC'D. BY REGISTRAR  | 25b. REGISTRAR'S SIGNATURE  |
| Wm. C. March F/H   | 1101 E. North Ave.  | OCT 15 1980  | P. H. H. H. H.  |

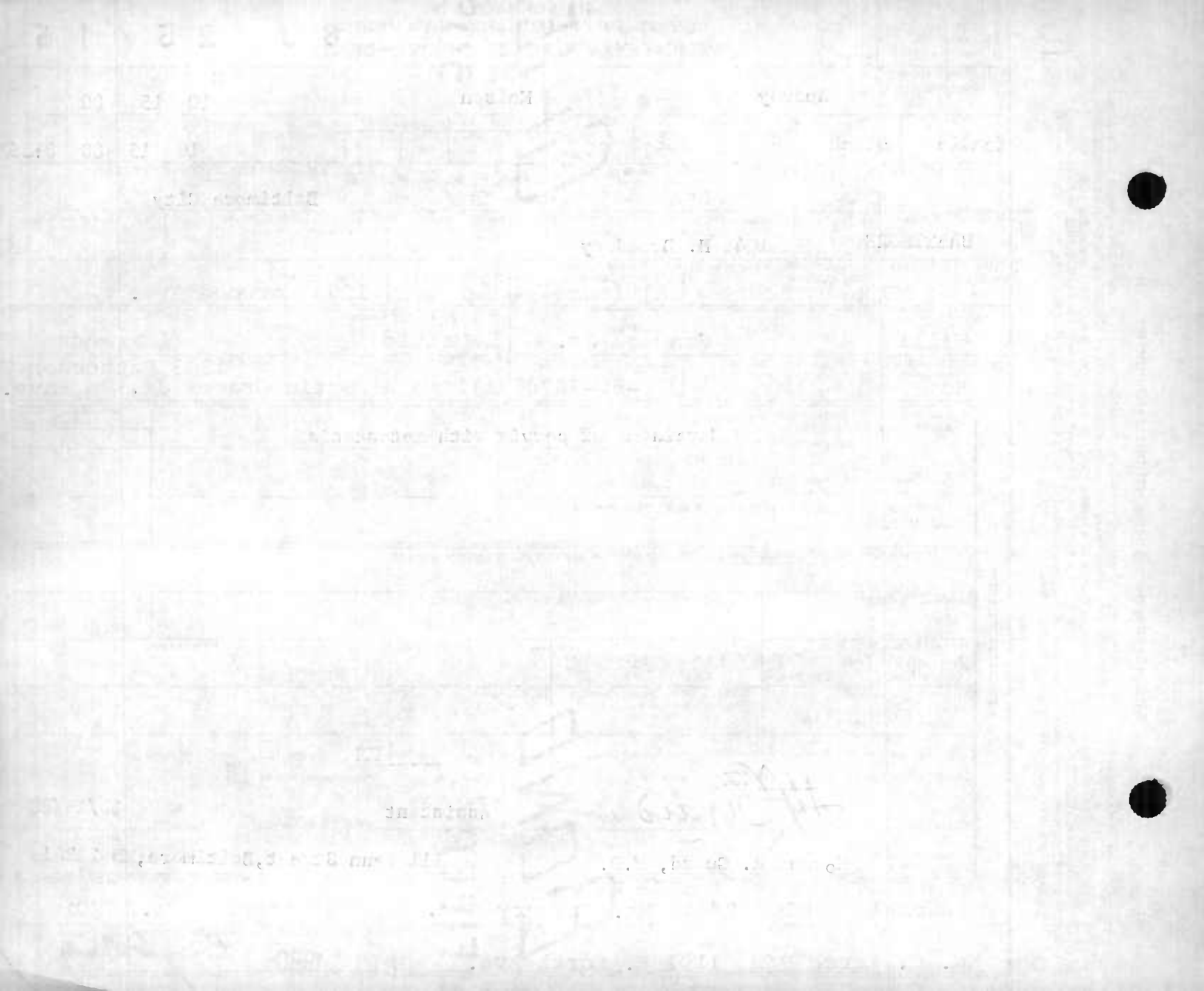
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

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27748BP

DHMH-17  
(VR A15 ME (1))  
15M7/76



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 80 25716  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 10 11 80  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dr. JAMES WHARTON NELSON   |  |   |  | 2b. HOUR 135 P M   |  |  |  |
| 3. SEX Male   |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR May 21, 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician  |  | 12b. KIND OF BUSINESS OR INDUSTRY Medicine   |  |
| 13a. STATE Maryland   |  |   |  | 13b. COUNTY Baltimore  |  | 13c. CITY OR TOWN Towson   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Thomas Nelson  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ireland  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes   |  |   |  | 16b. SOCIAL SECURITY NO. WW I 212 10 2740  |  | 17. INFORMANT ADDRESS Mrs. Jo N. Booze Towson, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) FRACTURE OF LEFT HIP; POSSIBLE RECENT CEREBROVASCULAR ACCIDENT  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION 3/19/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE (L) HIP   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11 19 80, to 10/11 19 80, that (I) (we) last saw the deceased alive on 10/11 19 80, and that in (my) (our) opinion he/she was dead at the time and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE W. Jenkins   |  |   |  | DEGREE   |  | 22c. DATE SIGNED 10/11/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Jenkins  |  |   |  | 22e. ADDRESS Mercy Hospital  |  | 22f. APPROVED BY MEDICAL EXAMINER <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 10/14/80  |  | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.  |  |
| 24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212   |  |   |  | 25a. DATE REC'D BY REGISTRAR OCT 14 1980   |  | 25b. REGISTRAR'S SIGNATURE   |  |

4605 York Road, Baltimore, Md. 21215  
Henry W. Jackson & Son, Co.  
Baltimore, Md.  
1980

RECEIVED BY HENRY W. JACKSON & SON, CO.

Yes WW I 212 to 214 Mr. J. N. Booz Town on, Md.

John Thomas Wilson  
Maryland - Prince George's County

Director

Attn: U. A.

White

U. A. - F. V. A. - U. A.

8 0 2 1 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 7 1 7  
CERTIFICATE OF DEATH

|  |  |   |   |
|--|--|---|---|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |   |
| FIRST MIDDLE LAST<br>MARLET C NESS JR  |  | MONTH DAY YEAR HOUR<br>10 1 80 5:47 P.M.  |   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |
| M  | W  | MONTH DAY YEAR<br>1 31 27   | 53 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| PA   | USA  |   | BALTIMORE CITY MD.  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| BALTIMORE  | UNIV. OF MARYLAND HOSP.  | FOR BOARD OF EDUC.  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  |
| MD   | BALTO  | COCKEYSVILLE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 13e. STREET ADDRESS   |   |
| FIRST MIDDLE LAST<br>MARLET C NESS JR  | FIRST MIDDLE LAST<br>RUTH EVERSOLE   | 10402 GREENTOP RD   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   | 17. INFORMANT   | ADDRESS   |
| UNKNOWN  | 161-20-2139  | BARBARA Z. NESS   | SAME  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) CORONARY ARTERY DISEASE (ARTERIOSCLEROTIC)<br>(c) CORONARY ARTERY BYPASS.<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
| 10/1/80  | CORONARY ARTERIOSCLEROSIS  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/28/80 19 80, to 10/1 19 80, that (I) (we) last saw the deceased alive on 10/1 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |   |
| 22b. SIGNATURE   | DEGREE   | 22c. DATE SIGNED  |   |
| Bhupinder Singh  | MD   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |   |
| BHUPINDER SINGH MD   | 1 HOSPITAL DR, # 35 CHEVERLY MD.   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |
| BURIAL   | 10/4/1980  | Salem   | JACOBUS PENN.   |
| 24. FUNERAL DIRECTOR   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |
| EVANS FUNERAL CHAPEL   | OCT 6 1980   |   |   |



8-11-53

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

CLASSIFICATION: [Illegible]

REFERENCE: [Illegible]

ADMINISTRATIVE: [Illegible]

NOTES: [Illegible]

APPROVAL: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

LOCATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

INITIALS: [Illegible]

RECEIVED: [Illegible]

FILED: [Illegible]

END



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 1 8  
REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) RICHARD NEUBERGER   |   | 10-28-80  |   | 1:15 A.M.  |  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>17 98   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Merry Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bohemia Steel |
| 13a. STATE<br>Md.   | 13b. COUNTY<br>--   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>820 N. Linwood Ave.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>BERNARD NEUBERGER   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine HERRING  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No  |   | 16b. SOCIAL SECURITY NO.<br>215-10-5682   |   | 17. INFORMANT<br>ADDRESS<br>Hattie Neuberger, wife, same address                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Esophageal carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Pneumonia  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/13, 19 80, to 10/28, 19 80, that (I) (we) last saw the deceased alive on 10/28, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>Patricia D. Smith MD  |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>10/28/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PATRICIA D. SMITH MD   |   | 22e. ADDRESS<br>MERCY HOSPITAL  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>10/31/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Bohemian National                              |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore  |   | COUNTY<br>BALTIMORE   |   | STATE<br>Md.   |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>Anthony McCready                                       |  |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 0 2 5 7 1 9

## CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |
|---|--|---|---|---|
| 1. DECEASED NAME (AKA Maurice THOMAS)<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 17 80  |   | 2b. HOUR<br>4:45 <sup>P</sup> M   |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Aug. 30, 1908  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Upholsterer | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>-  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Frank Onorato  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Marie Tumminello  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES<br>Yes WW II   |  | 16b. SOCIAL SECURITY NO.<br>212-03-9586   | 17. INFORMANT ADDRESS<br>Vera Onorato, wife, same address                       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (a) (this hospital) attended the deceased from 11/19 19 79, to 10/17 19 80, that (we) lost saw the deceased alive on 10-6 19 80, and that in my (a) (ur) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |
| 22b. SIGNATURE<br>George E. Lowe M.D.   |  | DEGREE<br>ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>     |   | 22c. DATE SIGNED<br>10-20-80  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George E. Lowe, M.D.   |  | 22e. ADDRESS<br>3105 Belair Road  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE<br>10/20/80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                    |   |
| 24. FUNERAL DIRECTOR<br>Schmunek Funeral Home, Inc.   | 25a. DATE REC'D. BY REGISTRAR<br>3331 Brehms Lane<br>Baltimore, Md. 21213  |   | 25b. DATE REC'D. BY REGISTRAR<br>OCT 21 1980                                    |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATION 8000

11/11/11

Handwritten signature or mark at the bottom left.

1000 10 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMM-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNIE F. O'DONNELL</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>31</b> YEAR <b>80</b> 2b. HOUR <b>9</b> <b>17</b> AM  |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>14</b> YEAR <b>98</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS<br>IF UNDER 1 YEAR: MONTHS <b>0</b> DAYS <b>0</b><br>IF UNDER 24 HRS: HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH CHARLES HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>428 Evesham Avenue</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Luther</b> MIDDLE <b>Justis</b> LAST <b>Phelps</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Florence</b> MIDDLE <b>Phelps</b> LAST <b>Phelps</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213 32 9050</b>  |  | 17. INFORMANT<br><b>Mrs. Helen E. Lemmon</b>  |  | ADDRESS<br><b>Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC SHOCK</b><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>MYOCARDIAL INFARCT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>10-25</b> , 19 <b>80</b> , to <b>10-31</b> , 19 <b>80</b> , that (we) lost<br>saw the deceased alive on <b>10-31</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.              |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>David Strobel</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10-31-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID STROBEL</b>  |  |   |  | 22e. ADDRESS<br><b>North Charles General Hospital, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/3/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto., Md.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS <b>4905 York Road Balto., Md. 21212</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lesley Kelly</b>  |  |

MEDICAL CERTIFICATION



Virginia

USA

xx

Homemaker

Own Home

Maryland

Baltimore

x

428 Evesham Avenue

Luther

Justis

Florence

Phelps

No

513 32 6030 Mrs. Helen E. Lammon

Same

x

Burial

11 1980

Lorraine Park

Baltimore

Md.

Henry W. Jenkins & Sons Co.

45 York Road, Baltimore, Md. 21212

NOV 3 1980

North Charles General Hospital, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | 80 25721 |  |
|--|--|--|--|--|--|--|--|--|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | FIR. NO.   |  |  |  |  |  |  |  |          |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>ORDWAY, RALPH   |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>10/13/80  |  | 2b HOUR<br>10:35 P.M.  |  |          |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>CAUC.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6-6-99   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |          |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.D.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.   |  |  |  |          |  |
| 10 CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>N. CHARLES GEN. |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED   |  | 12b KIND OF BUSINESS OR INDUSTRY<br>S. S.  |  |          |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>MD   |  | 13b COUNTY<br>—  |  | 13c CITY OR TOWN<br>BALTO.   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br>121 W. 27 <sup>TH</sup> ST.  |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>? —  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>— ?  |  |  |  |  |  |  |  |          |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>450-18-9100  |  | 17 INFORMANT ADDRESS<br>CLAYTON MORRIS (SAME)  |  |  |  |  |  |          |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Complicated by pneumonia<br>(c) following extravasation of urine |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |          |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |          |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |          |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |          |  |
| 22b SIGNATURE<br>Dr. Aruna Arwenderkar   |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c DATE SIGNED<br>10/13/80  |  |          |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. ARUNA ARWENDERKAR  |  |  |  | 22e ADDRESS<br>NORTH CHARLES GENERAL HOSPITAL  |  |  |  |  |  |          |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  |  | 23b DATE<br>10/14/80   |  | 23c NAME OF CEMETERY OR CREMATORY<br>SECURITY PROCESS  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. CO. MD.  |  |  |  |          |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Paul E. Charon  |  | ADDRESS<br>3617 Chestnut Ave   |  | OCT 17 1980  |  |  |  |  |  |          |  |

BP

1 2 3 4 5 6 7 8



*Handwritten signature*

0011 1100

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |  |  |  |   |  |
|---|--|---|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Elizabeth A. Oster</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Oct. 28, 1980</i>                   |  |  | 2b. HOUR<br>M  |  |  |   |  |
| 3 SEX<br><i>Female</i>  |  | 4 RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Feb. 1, 1908</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>72</i>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>714 Harvey St. Balto. Md.</i> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Factory Worker</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Md. Cup Corp.</i>  |   |  |
| 13a. STATE<br><i>Maryland</i>   |  |   | 13b. COUNTY<br><i>Baltimore</i>   |  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Dennis J. O'Brien</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Annie A. Beniak</i>       |  |  | 13e. STREET ADDRESS<br><i>714 Harvey St. Balto. Md.</i>  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>214-18-0875</i> |  |  | 17. INFORMANT<br>ADDRESS<br><i>Mr. William E. Oster, Same as above</i>   |  |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral</i><br><i>2008</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____               |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6-20</i> , 19 <i>80</i> , to <i>10-29</i> , 19 <i>80</i> , that (I) (we) lost<br>saw the deceased alive on <i>9-28</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Allen J. Feldman</i> MD  |  |   |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME<br><i>ALLEN J. FELDMAN, P.A.</i><br><i>SUITE 302 - GREEN SPRING STATION</i>   |  |   |   |  |  | 22e. ADDRESS   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |   | 23b. DATE FUNERAL HELD<br><i>Oct. 31, 1980</i>                                |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Cross Cemetery</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>McCurly Funeral Home, 130 E. Fort Ave. Balto. Md.</i>  |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 31 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Barry McBrady</i>   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Vertical text on the right margin, possibly a date or page number, including the characters 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |  | 8025723   |  |  |  |  |   |                                     |  |  |                                  |                         |   |              |  |   |  |  |                                       |  |  |
|---|--|--|---|--|--|--|--|--|--|---|--|--|--|--|---|-------------------------------------|--|--|----------------------------------|-------------------------|---|--------------|--|---|--|--|---------------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |  |  |  |  |  | REG. NO.  |  |  |  |  |   |                                     |  |  |                                  |                         |   |              |  |   |  |  |                                       |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST Mae MAE   |  |  | MIDDLE S.  |  |  | LAST Owen OWEN   |   |  | 2a DATE OF DEATH                         |  | MONTH DAY YEAR   |   | 2b HOUR                             |  |  |                                  |                         |   |              |  |   |  |  |                                       |  |  |
| 3 SEX   |  |  | 4 RACE  |  |  | 5 DATE OF BIRTH  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |   |  | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) |  | 7b CITIZEN OF WHAT COUNTRY?  |   | 8 BALTIMORE CITY OR COUNTY OF DEATH |  |  |                                  |                         |   |              |  |   |  |  |                                       |  |  |
| FEMALE  |  |  | White   |  |  | 6 MONTH DAY YEAR<br>3 1896   |  |  | 84 YRS   |   |  | South Carolina                           |  | U.S.A.   |   | Baltimore City MD.                  |  |  |                                  |                         |   |              |  |   |  |  |                                       |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b CITIZEN OF WHAT COUNTRY?   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  | 10 CITY OR TOWN OF DEATH                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                     | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY |                         |   |              |  |   |  |  |                                       |  |  |
| South Carolina  |  |  | U.S.A.  |  |  |  |  |  | Baltimore City   |   |  | Baltimore                                |  |  | North Charles Gen. Hospital   |                                     |  | Housewife  |                                  |                         |   |              |  |   |  |  |                                       |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |  |  |  |  | 13b INSIDE CITY LIMITS?   |  | 13c STREET ADDRESS                       |  | 14 FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME            |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |                                  | 16b SOCIAL SECURITY NO. |   | 17 INFORMANT |  |   |  |  |                                       |  |  |
| Maryland  |  |  |   |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 7014 River Drive Road                    |  | Elly   |   | Josephine                           |  | No   |                                  | 213-09-0203             |   | June Edwards |  |   |  |  |                                       |  |  |
| 14 FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b SOCIAL SECURITY NO.  |   |  | 17 INFORMANT                             |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410 - |                                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |                                  |                         |   |              |  |   |  |  |                                       |  |  |
| Elly  |  |  | Smith   |  |  | Josephine  |  |  | Snipes   |   |  | No                                       |  |  | 213-09-0203   |                                     |  | June Edwards   |                                  |                         | 7014 River Drive Road Balto. MD 21219                         |              |  |   |  |  |                                       |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410 -                     |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE ACUTE MYOCARDIAL INFARCTION |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) HHSUOD.   |  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) D. MELLITUS - CHF.  |   |  | 19a DATE OF OPERATION                    |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     |  | 20a AUTOPSY?   |                                  |                         | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |              |  |   |  |  |                                       |  |  |
|   |  |  |   |  |  |  |  |  |  |   |  |  |  |  |   |                                     |  |  |                                  |                         |   |              |  |   |  |  |                                       |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                     |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  | 22a I certify that (I) (this hospital) attended the deceased from 8-18-80 to 10-4-80, that (I) (we) last saw the deceased alive on 10-4-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  | 22b SIGNATURE Kenneth V.I. Rolston M.D.  |  |  | 22c DATE SIGNED 10-4-80   |                                     |  | 22d PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH V.I. ROLSTON        |                                  |                         | 22e ADDRESS NORTH CHARLES GENERAL HOSPITAL                    |              |  |   |  |  |                                       |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b DATE  |  |  | 23c NAME OF CEMETERY OR CREMATORY  |  |  | 23d LOCATION CITY OR TOWN  |   |  | 23e COUNTY                               |  |  | 23f STATE   |                                     |  | 24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc.                         |                                  |                         | 24b ADDRESS 7922 Wise Avenue, Dundalk, MD 21222               |              |  | 25a DATE REC'D. BY REGISTRAR OCT 6 1980 |  |  | 25b REGISTRAR'S SIGNATURE [Signature] |  |  |
| Burial  |  |  | 10/7/80   |  |  | Arlington National   |  |  | Arlington  |   |  | Virginia                                 |  |  |   |                                     |  |  |                                  |                         |   |              |  |   |  |  |                                       |  |  |

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 2 4

REG. NO.

|   |  |   |  |  |  |  |  |  |  |   |  |   |  |  |  |
|---|--|---|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BEN</b>         |  | FIRST<br><b>PAGE</b>  |  | MIDDLE<br><b>PAGE</b>  |  | LAST<br><b>PAGE</b>  |  | 2a. DATE OF DEATH<br>MONTH<br><b>10</b>                      |  | DAY<br><b>6</b>   |  | YEAR<br><b>80</b>   |  | 2b. HOUR<br><b>5:00AM</b>                        |  |
| 3 SEX<br><b>Male</b>                                      |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH<br><b>March</b>   |  | DAY<br><b>21</b>   |  | YEAR<br><b>1899</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>   |  | 7a. IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>   |  | 7b. IF UNDER 24 HRS<br>HOURS<br><b>0</b>         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b> |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                     |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> |  | MD.   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Auto Body Repair</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>    |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corp.</b> |  | 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b> |  | 13b. COUNTY<br><b>Balto.</b>                                       |  | 13c. CITY OR TOWN<br><b>Balto.</b>                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>612 N. Curley St.</b>   |  |  |  |
| 14 FATHER'S NAME<br>FIRST<br><b>unknown</b>               |  | MIDDLE<br><b>unknown</b>  |  | LAST<br><b>unknown</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST<br><b>unknown</b>                 |  | MIDDLE<br><b>unknown</b>                                     |  | LAST<br><b>unknown</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>           |  | 16b. SOCIAL SECURITY NO.<br><b>216-10-1641-A</b> |  |
| 17 INFORMANT<br><b>Robert Tarr (step-son)</b>             |  | ADDRESS<br><b>1109 Green Acre Rd</b>  |  |  |  |  |  |  |  |   |  |   |  |  |  |

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|--|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF PROSTATE</b>   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK NOT AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (1) <b>this hospital</b> attended the deceased from <b>10-8-80</b> to <b>10-6-80</b> , that (1) <b>we</b> last saw the deceased alive on <b>10-6-80</b> , and that in (my) <b>four</b> opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |

|  |  |  |  |  |  |                                    |  |
|--|--|--|--|--|--|------------------------------------|--|
| 22b. SIGNATURE<br><b>Y. K. Shetty</b>                            |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/6/80</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. Y. K. SHETTY</b> |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21201</b> |  |  |  |                                    |  |

|  |  |   |  |  |  |  |  |                      |  |       |  |
|--|--|---|--|--|--|--|--|----------------------|--|-------|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>10/9/80</b>                         |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b> |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Balto.</b>   |  | COUNTY<br><b>Md.</b> |  | STATE |  |
| 24 FUNERAL DIRECTOR<br><b>Scamirek Funeral Home, Inc.</b>  |  | ADDRESS<br><b>3331 Brehms Lane Balto. Md. 21213</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 7 1980</b>     |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |                      |  |       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | 8 0 2 5 7 2 5<br>REG. NO.  |   |  |  |                        |  |
|--|--|--|--|--|--|---|--|--|------------------------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  |  | 2b. HOUR               |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Lydia Palmer</b>  |  |  |  |  | <b>October 31, 1980</b>  |   |  |  | <b>7 P<sup>M</sup></b> |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>June 16, 1901</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>England</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>England</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |  |  |                        |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1523 Winston Avenue</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook</b>                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>   |                        |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1523 Winston Avenue 21239</b>  |                        |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Ernest Edrupt</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alice Louise Carney</b> |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219 28 9584A</b>  |  | 17 INFORMANT ADDRESS<br><b>Marguerite Schulze 4303 Newport Ave. 21211</b>  |  |   |  |  |                        |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myo infarct</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ch. Art Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden-minutes</b><br><b>5 yrs</b>                                      |                        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |  |  |  |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <b>76</b> , to <b>Dec</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Oct 15</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                    |  |  |  |  |  |   |  |  |                        |  |
| 22b. SIGNATURE<br><i>Michael H. Keleman</i>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>11/3/80</b>   |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Michael H. Keleman</b>   |  |  |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>   |  |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4 Nov. 80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                           |  |  |                        |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Burgee Funeral Home</b>   |  |  |  | ADDRESS<br><b>3631 Falls Rd. 21211</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                        |  |

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Table 1. *Continued*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |                          |   |  |
|---|--|---|--|---|--|--|--------------------------|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |                          |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CHARLES W. PANDZIK</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 4 80</b>               |  | 2b. HOUR<br><b>P. M.</b> |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 9 12</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>   |                          | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>OHIO</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |                          |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>ELECTRICIAN</b>   |                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                          | 13e. STREET ADDRESS<br><b>3700 GREENVALE ROAD</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN PANDZIK</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ANN UNKNOWN</b> |  |                          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>---</b>  |  | 17. INFORMANT ADDRESS<br><b>AURILLIA J. PANDZIK 3700 GREENVALE ROAD</b>   |  |  |                          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MASSIVE PULMONARY EDEMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CORONARY ARTERIOSCLEROSIS</b><br>Approximate interval between onset and death:<br><b>410- HOURS</b><br><b>HOURS</b><br><b>YEARS</b> |  |   |  |   |  |  |                          |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |                          |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |                          |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                          |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEBRUARY</b> 19 <b>78</b> , to <b>JULY</b> 19 <b>78</b> , that (I) (we) last saw the deceased alive on <b>JULY 12</b> 19 <b>78</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |                          |   |  |
| 22b. SIGNATURE<br><i>Dr. N. M. Machiran</i>   |  | DEGREE<br><b>Dr. N. M. MACHIRAN</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                          | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. N. M. MACHIRAN</b>  |  |   |  | 22e. ADDRESS<br><b>4713 Leeds Ave., ARBUTHUS MD.</b>  |  |  |                          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10/8/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>ELKRIDGE HOWARD MD.</b>   |                          |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME 4107 WILKENS AVE.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Patrick McBrady</i>   |                          |   |  |

MEDICAL CERTIFICATION



BALTIMORE CITY

ST. ANNE'S HOSPITAL

BALTIMORE

CASE NO. 1000

[Faint, mostly illegible text covering the rest of the page, likely a medical record or form.]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 2 7

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10-17-80   |  | 2b. HOURS<br>10 A.M.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Airlean Boswell Parker  |  | 3. SEX<br>Female   |  | 4. RACE<br>Col.   |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jun 12, 1889  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>19 Macomb Co. GA.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>30 BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE STREET ADDRESS)<br>35 Ardleigh Nursing Home |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Housewife   |  |
| 13a. STATE<br>35 Maryland   |  | 13b. COUNTY<br>BALTO.  |  | 13c. STREET ADDRESS<br>2095 Rockrose Ave.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>300 Rev. Sonny Weaver   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Mae Dorsey   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>1 NO  |  |
| 16b. SOCIAL SECURITY NO.<br>191-03-8588D  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Hildagardeis Boswell 1723 Inkwood Rd  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Vascular Accident<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASCVA<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (was hospital) attended the deceased from 7-30, 1980, to 10-16, 1980, that (I) (was) lost saw the deceased alive on 10-8, 1980, and that in (my) (true) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.  |  |  |  |   |  |
| 22b. SIGNATURE<br>L. Kemper Owens   |  | DEGREE<br>M.T.I.   |  | 22c. DATE SIGNED<br>10-20-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. Kemper Owens  |  | 22e. ADDRESS<br>300 Armory Place Balto, MD. 21201  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/21/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cem.  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD.   |  | 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ 2222 W. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1980  |  |
| 25b. REGISTRAR'S SIGNATURE<br>F. J. Kelly   |  |  |  |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be distributed for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 5 7 2 8<br>REG. NO.   |  |   |  |  |
|--|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>CARRIE B. PARKER</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10-24-80</b>   |  |   |  | 2b. HOUR<br><b>7 20 A M</b>                              |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4-19-92</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Minnesota</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Federal Hill Nursing Ctr.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant Own.</b>   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3570 D. Hanover St.</b>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Unknown Brundrette</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown Rudgeon</b>  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>573-22-1268A</b>  |  | 17. INFORMANT ADDRESS<br><b>Ma. Lloyd Cook, Same as above</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4392 Organic Brain Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/15/78</b> , 19____, to <b>10/24/80</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/24/80</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>E. J. Fulmer, M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>10/24/80</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Folkmar</b>  |  |  |  | 22e. ADDRESS<br><b>Fed Hill Nursing Home</b>  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Oct. 27, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>McQuilly Funeral Home, 237 E. Patapsco Ave. Balto. Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>21225 OCT 24 1980 P. J. H. H. H.</b>   |  |   |  |  |



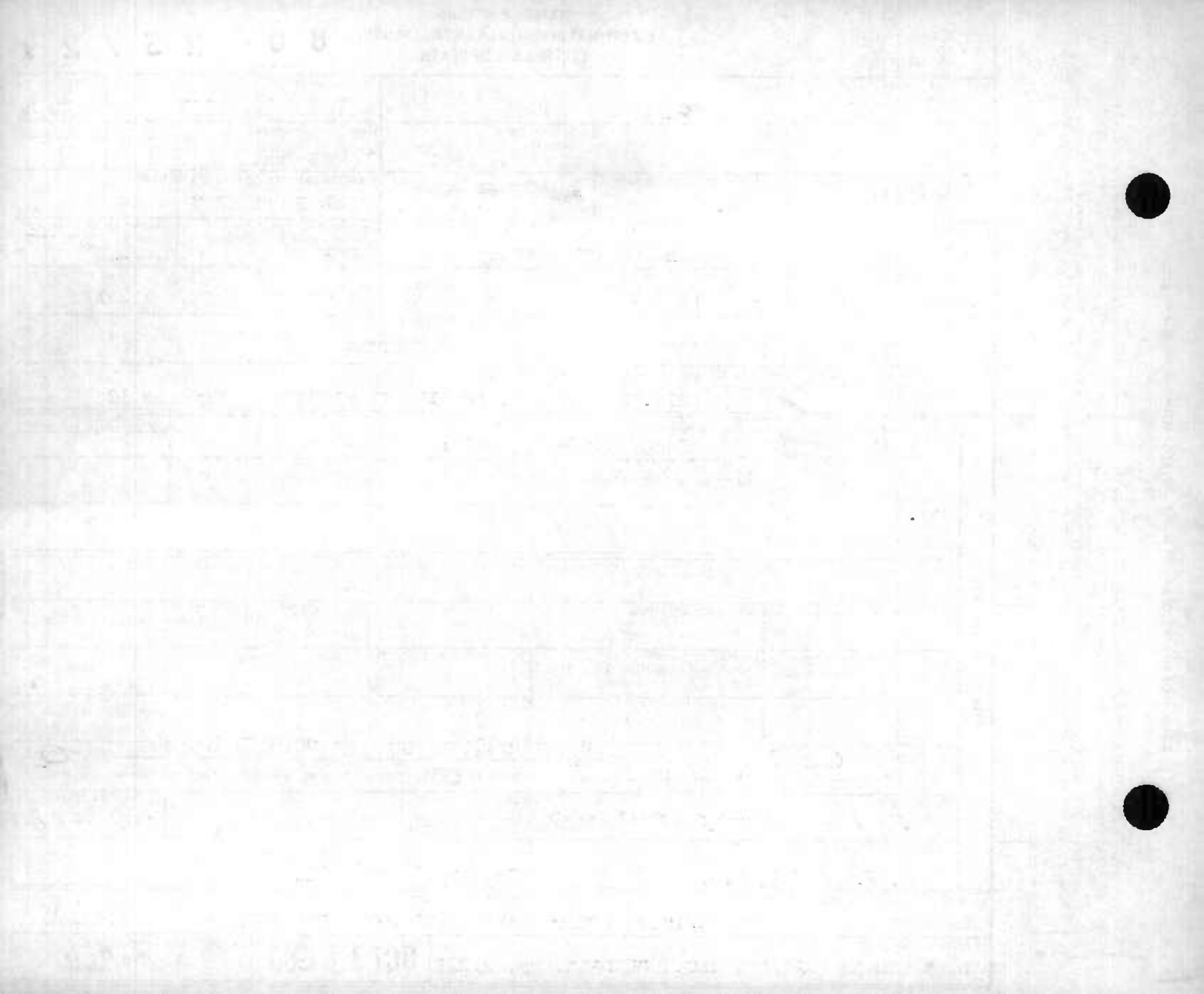
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8025729   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DOC CARROLL PATE</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 14, 1980</b>   |  |   |  |
| 3. SEX <b>MALE</b>   |  |  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 25 1917</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <b>63 yrs.</b>   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WEDDED</b> <input checked="" type="checkbox"/> <b>SEPARATED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHURCH HOSPITAL, INC.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMAN</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT MARINE</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |   |  |
| 13a. STATE <b>MARYLAND</b>   |  | 13b. COUNTY <b>---</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES ? PATE</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHARITY ? ?</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>216.12.0017</b>  |  | 17. INFORMANT ADDRESS <b>M. ANTOINETTE FINSTER Same as 13c</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1990</b> IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, ORIGIN ?</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 11, 1980</b> to <b>OCTOBER 14, 1980</b> , that (I) (we) last saw the deceased alive on <b>OCTOBER 14, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                          |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>A. F. Nazemi, M.D.</b> DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c. DATE SIGNED <b>10/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. F. NAZEMI, M.D.</b>  |  |  |  | 22e. ADDRESS <b>100 N. BROADWAY BALTIMORE, MD 21231</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>   |  | 23b. DATE <b>10/15/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CREMATORY</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS <b>WALTER BROOKS BRADLEY, INC., DUNDALK, MD. 21222</b>   |  |  |  | 25. DATE RECEIVED BY REGISTRAR <b>OCT 17 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Walter Brooks Bradley</b>   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 5 7 3 0<br>REG. NO.   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>DAHYABHAI C. PATEL</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 26, 1980</b>   |  | 2b. HOUR<br><b>10:26 PM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>India</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11/4/1904</b>   |  | 6. AGE [IN YEARS LAST BIRTHDAY] YRS.<br><b>75 yrs.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>India</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>India</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>               |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto Mfgr.</b>  |  |
| 13a. STATE<br><b>India</b>   |  | 13b. COUNTY<br><b>Bombay</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>A 12 Nutannagar</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Chatabhia Patel</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Zaverben</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT ADDRESS<br><b>Bhanuben Patel---Same as 13c</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cumulative Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>atherosclerosis</b> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> , 19 <b>80</b> , to <b>10/26</b> , 19 <b>80</b> , that (I) (we) lost the deceased alive on <b>10/26</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Dr. A. Bradshaw MD</b>   |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/26/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>10/27/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Walter Brooks Bradley Inc. Balto., Md. 21222</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 80 25731  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
| Elbert H  |  | Patterson  |  |   |  |  |  | 10 27 80   |  | 1 P M  |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN                    |  |
| Male  |  | Black  |  | 1 22 29   |  | 51 YRS.  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |
| Baltimore   |  | USA  |  |   |  | Baltimore City MD.   |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |  |  |  |  |
| Balt City   |  | BCRP, University Hosp  |  |   |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |  |  |  |  |
| Construction  |  |  |  |   |  |  |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |  |  |
| MD  |  | Baltimore  |  | Baltimore   |  |  |  | 5442 Price Ave   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |  |  |  |  |  |  |
| Howard d Patterson  |  | Elizabeth Field  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT ADDRESS  |  |  |  |  |  |  |  |
| yes   |  | II   |  | 220 201962 Elizabeth Johnson 2407 St. Stephens Ct   |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2080  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |  |   |  |  |  |  |  | 3 mo   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |  |  |  |  |
| Pneumonia   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/25 19 80, to 10/27 19 80, that (II) (we) last saw the deceased alive on 10/27 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE  |  |  |  | 22c. DATE SIGNED   |  |  |  |
| Elizabeth Poplin  |  | M  |  |   |  | 27 Oct 80  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |  |  |  |  |  |  |
| Elizabeth Poplin  |  | 22 S. Greene St. Balto MD.   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| Burial  |  | 11/1/80  |  | Arbutus Memorial pk   |  | Balto. Co. MD  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.   |  |  |  |   |  | OCT 28 1980  |  | [Signature]  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |              |                                     |   |  |   |   |  |  | 8  | 0                                 | 2  | 5 | 7   | 3 | 2   |  |
|--|--|--------------|-------------------------------------|---|--|---|---|--|--|--|-----------------------------------|--|---|---|---|---|--|
| FOR STATE REGISTRAR  |  |              |                                     |   |  |   |   |  |  | REG. NO.   |                                   |  |   |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Lillian C. Patterson  |  |              |                                     |   |  |   |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 / 7 / 80  |                                   |  |   | 2b. HOUR<br>225 PM  |   |   |  |
| 3. SEX<br>F  |  | 4. RACE<br>B |                                     | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 28 13   |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.                        |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                   | IF UNDER 24 HRS.<br>HOURS MIN  |   |   |   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>md.   |  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.                          |  |  |                                   |  |   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore md.   |  |              |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |   |   |   |  |
| 13a. STATE<br>Md.  |  |              |                                     |   |  |   |   |  |  | 13b. COUNTY<br>city  |                                   | 13c. CITY OR TOWN<br>Baltimore md.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>1828 W Fayette St. |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Marris  |  |              |                                     |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nellie Griffin |   |   |  |  |  |                                   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |              |                                     | 16b. SOCIAL SECURITY NO.<br>117-18-9735   |  |   | 17. INFORMANT ADDRESS<br>Dempsey E. Patterson 1828 W. Fayette St. |  |  |  |                                   |  |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Asquamous cell CA of MORT Lung</u><br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>With extension to the medical time, months</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |              |                                     |   |  |   |   |  |  | APPROPRIATE PERIOD BETWEEN ONSET AND DEATH<br><u>months</u>  |                                   |  |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |              |                                     |   |  |   |   |  |  |  |                                   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |              |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |              |                                     | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |  |   |   |   |   |  |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |              |                                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |                                   |  |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-24</u> , 19 <u>80</u> , to <u>Oct. 7</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |              |                                     |   |  |   |   |  |  |  |                                   |  |   |   |   |   |  |
| 22b. SIGNATURE<br>Agustín del Campo MD   |  |              |                                     |   |  |   |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   |  |   | 22c. DATE SIGNED<br>10-7-80   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Agustin del Campo   |  |              |                                     |   |  |   |   |  |  | 22e. ADDRESS<br>Bon Secours Hosp. Balt., Md.   |                                   |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |              |                                     | 23b. DATE<br>10-11-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem.   |   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>B A. A. Co. Md  |                                   |  |   |   |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Isaiah L. Brown & Son PA  |  |              |                                     |   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980   |                                   |  |   | 25b. REGISTRAR'S SIGNATURE<br>Rafaela   |   |   |  |
| Brown-Thompson PA Funeral Home 1913 W. Baltimore St.   |  |              |                                     |   |  |   |   |  |  |  |                                   |  |   |   |   |   |  |

BP



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*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 5 7 3 3   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARY JO PATTERSON</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 16 80</b>  |  | 2b. HOUR<br><b>1348</b> M  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 29, 1931</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHN HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |
| 13a. STATE<br><b>Georgia</b>   |  | 13b. COUNTY<br><b>Smyrna</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1465 Forest Drive</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jesse Cook</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>H. Camp</b>   |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Castellaw Funeral Home, Smyrna, Ga.</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b><br>5168<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>INTERSTITIAL PNEUMONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ON DAY 21 AFTER BONE MARROW TRANSPLANT FOR APLASTIC ANEMIA</b><br>APLASTIC ANEMIA<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>APLASTIC ANEMIA</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b> |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/2/80</b> 19____, to <b>10/16/80</b> 19____, that (I) (we) lost<br>saw the deceased alive on <b>10/16/80</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/16/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT Y. OIKAWA M.D.</b>  |  | 22e. ADDRESS<br><b>JOHN HOPKINS HOSPITAL BALTIMORE MD</b>   |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>10/17/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Georgia Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Smyrna, Ga.</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |  |   |  | 24. DATE RECEIVED BY REGISTRAR<br><b>OCT 17 1980</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |
| 4905 York Road Balto., Md. 21212   |  |   |  |   |  |  |   |

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July 1944

July 1944

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

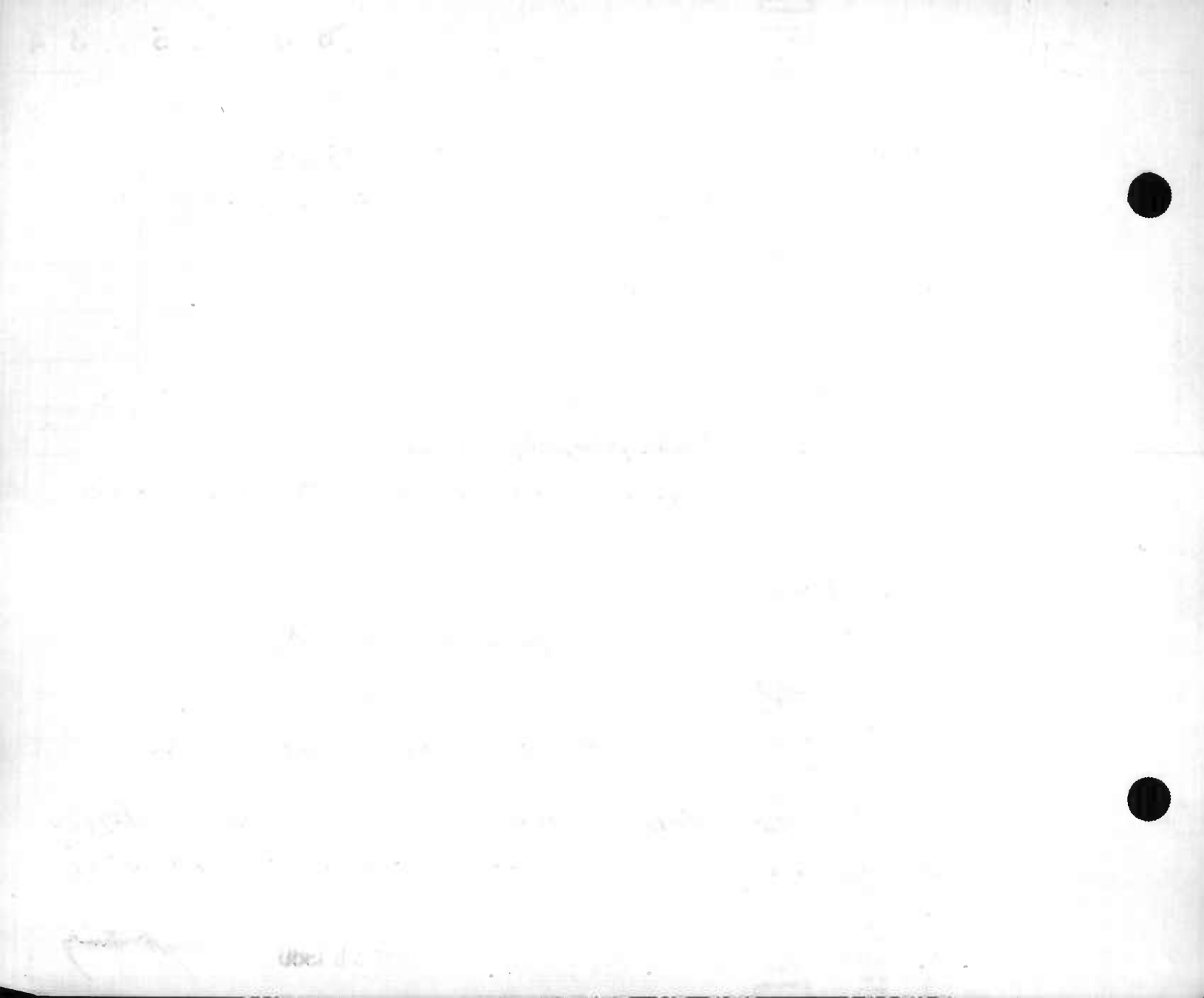
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |   |  | 80   | 25734 |
|--|--|---|--|---|--|---|--|---|--|--|-------|
| 1 - FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |   |  |  |       |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a DATE OF DEATH MONTH DAY YEAR                                 |  | 2b HOUR                                      |       |
| WILLIE   |  | PATTERSON   |  |   |  |   |  | October 26, 1980  |  | M  |       |
| 3 SEX  |  | 4 RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR MONTHS DAYS                                     |  | IF UNDER 24 HRS HOURS MIN.                   |       |
| Male   |  | Negro   |  | 6 3 93  |  | 87 yrs.   |  |   |  |  |       |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |   |  |  |       |
|  |  | USA   |  |   |  | Baltimore City MD.  |  |   |  |  |       |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                       |  |   |  |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b KIND OF BUSINESS OR INDUSTRY             |       |
| Baltimore  |  | 1618 25th Street  |  |   |  |   |  |   |  |  |       |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |   |  |   |  |  |       |
| 13a STATE  |  | 13b COUNTY  |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS?   |  | 13e STREET ADDRESS  |  |  |       |
| MD   |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1618 25th St.   |  |  |       |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |   |  |  |       |
| Unkn   |  |   |  | Unkn  |  |   |  |   |  |  |       |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS  |  |   |  |  |       |
| Yes  |  |   |  | WWI   |  | 298-16-7385   |  | Josephine Patterson 1618 E. 25th St.                            |  |  |       |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Squamous Cell Carcinoma of the Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>2 yrs</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Weight Loss</u>  |  |   |  |   |  |   |  |   |  |  |       |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a AUTOPSY?  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |       |
| NONE   |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |  |       |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |       |
|  |  | P.M. 19   |  |   |  |   |  |   |  |  |       |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |       |
|  |  |   |  |   |  |   |  |   |  |  |       |
| 22a I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>80</u> to <u>Oct</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>August</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |  |       |
| 22b SIGNATURE  |  | DEGREE  |  |   |  |   |  | 22c DATE SIGNED   |  |  |       |
| <u>Dorothy Snow M.D.</u>   |  | M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  |   |  | 10/27/80  |  |  |       |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS   |  |   |  |   |  |   |  |  |       |
| Dorothy Snow   |  | 22 S. Greene St. Balt 21201   |  |   |  |   |  |   |  |  |       |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION CITY OR TOWN COUNTY STATE                              |  |   |  |  |       |
| Burial   |  | 10/31/80  |  | Baltimore Cem.  |  | Baltimore, Md.  |  |   |  |  |       |
| 24 FUNERAL DIRECTOR NAME   |  |   |  | 24b ADDRESS   |  | 25a DATE REC'D. BY REGISTRAR  |  | 25b REGISTRAR'S SIGNATURE                                       |  |  |       |
| Wm. C. March F/H   |  |   |  | 1101 E. North Ave.  |  | OCT 28 1980   |  | <u>Richard H. H. H.</u>   |  |  |       |

BP

DHMH-16 20M  
(VRA 15, 4) 7/78





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

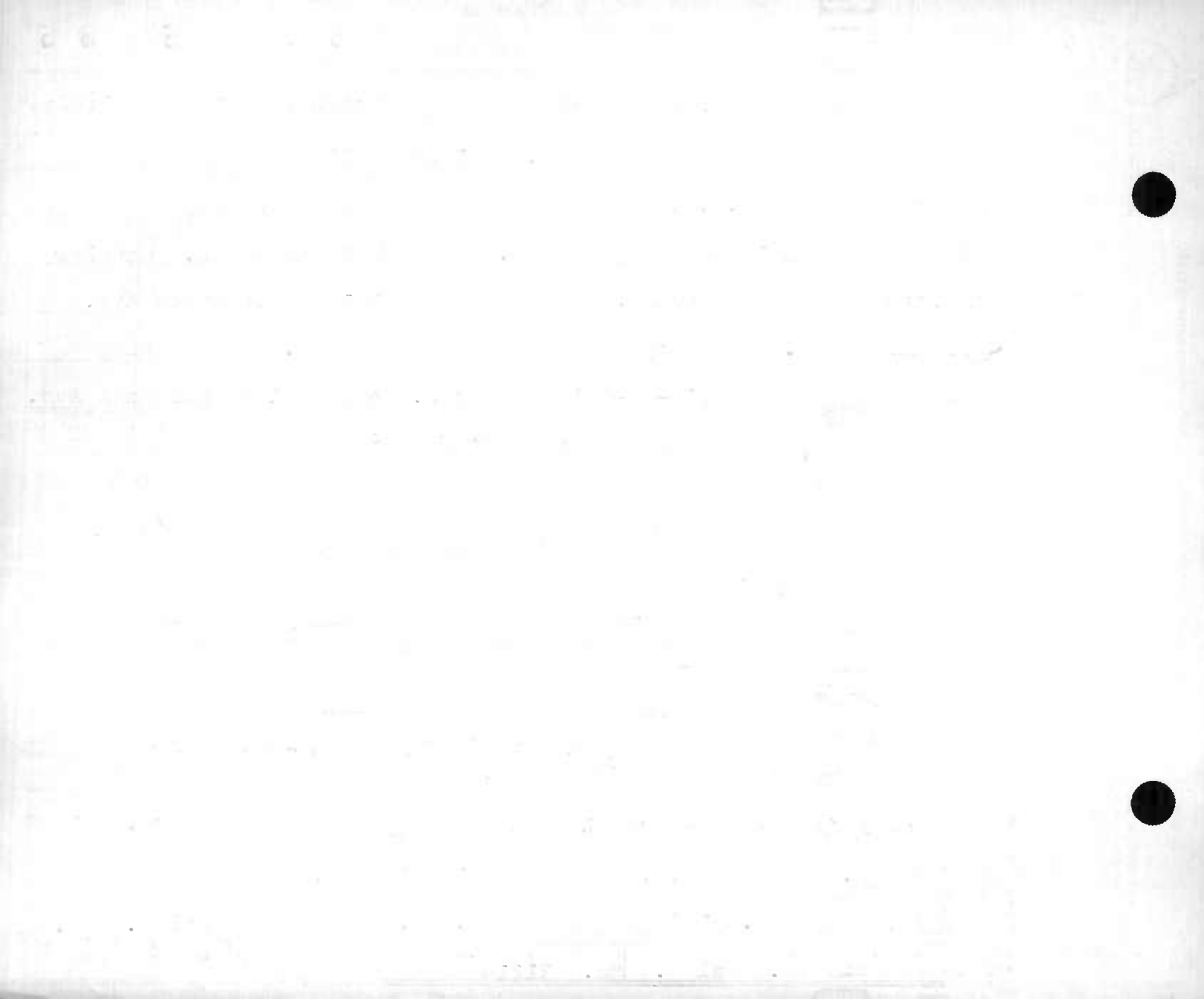
8 0 2 5 7 3 5  
REG. NO.

|   |  |   |   |  |  |  |  |   |  |
|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARTIN MARION PAYNE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 5, 1980</b> |  |  | 2b. HOUR<br><b>3:45a<sub>M</sub></b>   |  |   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 24, 1908</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>72</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 <b>BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>Baltimore City</b> MD.                        |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2917 Christopher Ave.</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chairman of Bd.</b>     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Candles</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>   |  | 13b COUNTY<br><b>Baltimore</b>  |   | 13c CITY OR TOWN<br><b>Baltimore</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>2917 Christopher Ave.</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur M. Payne</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia B. Vane</b>  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-07-7920A</b>   |   | 17 INFORMANT ADDRESS<br><b>James A. Payne, 6209 Fair Oaks Ave.</b>   |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary A.S.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b> |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>acute</b><br><b>1973.</b><br><b>10 yr</b>                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>NO</b>   |  |   |   |  |  |  |  |   |  |
| 19a DATE OF OPERATION<br><b>NO</b>  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NO</b>  |   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/3</b> , 19 <b>72</b> , to <b>10/5</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>9/17</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |   |   |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>David A. Oursler, M.D.</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |  |  | 22c. DATE SIGNED<br><b>Oct. 6, 1980</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David A. Oursler, M.D.</b>   |  |   |   | 22e ADDRESS<br><b>7401 Osler Dr.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>Oct. 8, 1980</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville, Balto., Md.</b>                     |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 7 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry Helms</b>   |  |   |  |
| 6009 Harford Rd., Balto., Md. 21214   |  |   |   |  |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |                  |   |  |   |  | REG. NO. 25736                               |  |
|--|-------------------------|--|--|---|------------------|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Michael William Peeples</b>   |                         |  |  |   |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> 10 9 19 80<br>PRONOUNCED DEAD <input type="checkbox"/> 10 9 19 80 |  | 2b. HOUR<br>M 9:30<br>P M   |  |  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 12 59</b>  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>21 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>10 9 19 80</b>   |  | 2d. HOUR<br>M 9:30<br>P M   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Shipping Clerk</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Seaboard</b>                                |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Lansdowne</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET ADDRESS<br><b>Iron &amp; Steel<br/>404 Third Avenue, 21227</b>          |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles T. Peeples</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Smallwood</b>   |                  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>218-74-5887</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Charles Peeples 404 Third Avenue</b>   |                  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Multiple gunshot wounds (handgun)</b><br>IMMEDIATE CAUSE (a) <b>9650</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                         |  |  |   |                  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR MIN MONTH DAY YEAR<br><b>8:15 P.M. 10-9- 19 80</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot.</b>   |                  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>bldg.</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>730 W. Ostend St., Balto. Md.</b>   |                  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .   |                         |  |  |   |                  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |                         | M.D.<br><b>Margarita A. Korell, M.D.</b>   |  | TITLE (SPECIFY)<br><b>Assistant</b>   |                  | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>10-10-80</b>  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                         | <b>Margarita A. Korell, M.D.</b> ADDRESS <b>111 Penn St.</b>   |  |   |                  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>10-13-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd</b>  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ellicott City Howard Md.</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>  |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Potter</i>   |                  |   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |   | 8 0 2 5 7 3 7  |  |
|---|--|---|--|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>EVA H. PERATT   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 10 80   |  | 2b. HOUR<br>5:30 A.M.  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 17, 1888   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bookkeeper                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Printing Co.                                    |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |   |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>15 Charles Plaza  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank G. Marple   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah C. Blodgett  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>272 10 5458   |  | 17. INFORMANT<br>Valentine M. Peratt  |  |  |   |  |  |
|   |  |   |  |   |  | ADDRESS<br>Same   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>RML pneumonia</u><br>436 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CVA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <u>9/23</u> , 19 <u>80</u> , to <u>10/10</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>10/10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u><br>DEGREE  |  |   |  |   |  | 22c. DATE SIGNED<br>10/16/80  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. Henderson   |  |   |  |   |  | 22e. ADDRESS<br>Mercy Hospital Baltimore MD.  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   |  | 23b. DATE<br>10/11/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                            |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 10 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                     |   |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 / 3 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph A. Perches</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>1</b> YEAR <b>80</b> |   |  | 2b. HOUR<br><b>6<sup>10</sup> PM</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>8</b> YEAR <b>18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Savannah, Ga.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Simms Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>College Admin</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Uni. Morgan State</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1623 Lockwood Rd</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>Abram</b> MIDDLE <b>Perches</b> LAST <b>Perches</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Sarah</b> MIDDLE <b>Dukes</b> LAST <b>Dukes</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>World War 11</b>   |  | 17. INFORMANT ADDRESS<br><b>Dr. Augustus A. Adair-1539 Kingsway Road</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>Metastatic Lung Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>80</b> , to <b>October</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Oct 1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Marshall A. Levine</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/1/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marshall A. Levine, MD.</b>   |  | 22e. ADDRESS<br><b>711 W. 40th St, Baltimore, MD, 21211</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/4/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore Co.</b> COUNTY <b>Maryland</b> STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Herbert E. Nutter-3035 W. North Ave.</b> ADDRESS  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 3 9

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Rou</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 26, 1980</b> |   |  | 2b. HOUR<br><b>5:40p M</b>  |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 27 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 13e. STREET ADDRESS<br><b>1008 Ashland Court</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <input type="checkbox"/><br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>227-16-8391</b>  |  | 17. INFORMANT<br><b>Robert Williamson</b> ADDRESS<br><b>229 S. Mason Court</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>Probable Pneumonia</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (this hospital) attended the deceased from <b>October 26, 1980</b> , to <b>October 26, 1980</b> , that (we) lost<br>saw the deceased alive on <b>October 26, 1980</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated<br>above, (I/we) did not view the body after death. |  |   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Eric Fisher</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>10/27/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eric Fisher, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>C/o Maryland General Hospital</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/31/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Calvary Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm.C. March Funeral Home Inc</b>   |  |   |  | ADDRESS<br><b>1101 E. North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1980</b>   |   |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |   |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 4 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |                             |  |  |  |  |  |  |
|--|--|---|---|---|-----------------------------|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>PERL MEYER PERLMAN</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>oct 24<sup>th</sup> 80</b> |   | 2b HOUR<br><b>9:38 P.M.</b> |  |  |  |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 25, 1900</b>   |                             | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  | IF UNDER 72 HRS<br>HOURS MIN   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                             | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |   |   |                             | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PROPRIETOR</b>           |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>DURAPAK CO.</b>                               |  |  |  |
| 13a STATE<br><b>MARYLAND</b>   |  | 13b COUNTY<br><b>BALTO.</b>   |   | 13c CITY OR TOWN<br><b>BALTIMORE</b>  |                             | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e STREET ADDRESS<br><b>11 SLADE AVE., APT. 814 #21208</b>                          |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>AARON PERLMAN</b>  |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE POLLACK</b>   |                             |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   |   | 16b SOCIAL SECURITY NO.<br><b>215-07-9724</b>   |                             | 17 INFORMANT ADDRESS<br><b>MRS. REBECCA PERLMAN 11 SLADE AVE., APT. 814 #21208</b>             |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4440 Atherosclerotic Heart Dis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>acute myocardial</b><br><b>Heart Failure infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic Mellitus</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>70 yrs</b><br><b>4 yrs</b><br><b>4 years</b> |  |   |   |   |                             |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |                             |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                             | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19 <b>80</b> , to <b>10/24/80</b> , that (I) (we) lost saw the deceased alive on <b>10/21</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                             |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Sol Smith</b>   |  |   |   | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                             |  |  | 22c. DATE SIGNED<br><b>10/24/80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sol Smith</b>  |  |   |   | 22e. ADDRESS<br><b>6810 Park Heights me 21215</b>   |                             |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |   |   | 23b. DATE<br><b>10-26-80</b>  |                             | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON (CHIZUK AMONO)</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>                       |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>   |  |   |   |   |                             | 25a. DATE RECEIVED BY REGISTRAR<br><b>00128 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert Helms</i>                                    |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 4 1  
REG. NO.

|   |  |  |  |  |  |  |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--------------------------------------|--|-----------------------------------|--|----------|--|--------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH  |  |                                      |  | MONTH                             |  | DAY      |  | YEAR   |  | 2b. HOUR   |  |
| CHRISTOPHER C.  |  |  |  |  |  | PERSON   |  | OCTOBER 19, 1980   |  |                                      |  |                                   |  |          |  |        |  | 10:05 AM   |  |
| 3. SEX  |  | Male   |  | 4. RACE  |  | Negro  |  | 5. DATE OF BIRTH   |  | MONTH                                |  | DAY                               |  | YEAR     |  | 6. AGE |  | 7. YRS.  |  |
|   |  |  |  |  |  |  |  | 1  |  | 7                                    |  | 22                                |  | 58       |  |        |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | N.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                                   |  |          |  |        |  |  |  |
|   |  |  |  |  |  |  |  | BALTIMORE CITY MD  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                  |  | THE JOHNS HOPKINS HOSPITAL                                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |          |  |        |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS                  |  |                                   |  |          |  |        |  |  |  |
|   |  | MD   |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 36 Minklen Ct.                       |  |                                   |  |          |  |        |  |  |  |
| 14. FATHER'S NAME   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 15. MOTHER'S MAIDEN NAME   |  | FIRST                                |  | MIDDLE                            |  | LAST     |  |        |  |  |  |
| X P   |  |  |  |  |  | Person   |  | Caddie   |  |                                      |  |                                   |  | Robinson |  |        |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | No   |  | 16b. SOCIAL SECURITY NO.   |  | 246-30-0870  |  | 17. INFORMANT  |  | ADDRESS                              |  |                                   |  |          |  |        |  |  |  |
|   |  |  |  |  |  |  |  | Arthur L. Fleming  |  | 2321 Odell Ave.                      |  |                                   |  |          |  |        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>probable respiratory arrest</u><br><u>1539</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>renal failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>metastatic colon carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br><u>years</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br><u>none</u> |  |  |  |  |  |  |  |  |  |                                      |  |                                   |  |          |  |        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u><br><u>2 weeks</u> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| none recent   |  | originally for colon cancer  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
|   |  |  |  |  |  |  |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN   |  | COUNTY   |  | STATE                                |  |                                   |  |          |  |        |  |  |  |
|   |  |  |  |  |  |  |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>80</u> , to <u>10/19</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/19</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| 22b. SIGNATURE<br><u>Julia Haller Yeo M.D.</u>  |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>10/19/80</u>                            |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JULIA H. YEO</u>  |  | 22e. ADDRESS<br><u>JOHNS HOPKINS HOSPITAL</u>                          |  |  |  |  |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN                                  |  | COUNTY   |  | STATE                                |  |                                   |  |          |  |        |  |  |  |
| Burial  |  | 10/25/80   |  | Ayden Cem.   |  | Greenville   |  |  |  | N.C.                                 |  |                                   |  |          |  |        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |
| Wm. C. March F/H  |  | 1101 E. North Ave.   |  | OCT 21 1980  |  | <u>Listy H. Hardy</u>  |  |  |  |                                      |  |                                   |  |          |  |        |  |  |  |

*[Faint, illegible handwriting on lined paper]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |  |  |   |  | REG. NO. 25742  |  |
|--|--|-------------------------|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |                         |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James W. Peterkin</b>   |  |                         |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 10 28 19 80 |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3 17 49</b>  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>31</b> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD <b>10 28 19 80</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland Penitentiary</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY             |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  | 13e. STREET ADDRESS<br><b>414 E. Oliver St.</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>James Peterkin</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Roberta Floyd</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>  |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>   |  | 17. INFORMANT ADDRESS<br><b>Roberta Peterkin 414 E. Oliver St.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drowning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                         |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR <b>7:05 P.M. 10 28 80</b>                                   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject drowned in tub</b> |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Penitentiary</b>   |  | 21f. LOCATION<br>STREET <b>401 Forrest</b> CITY OR TOWN <b>Baltimore,</b> COUNTY STATE <b>Md.</b>              |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b> M.D. MEDICAL EXAMINER  |  |  |  | DATE SIGNED <b>10/29/80</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |  |                         |  | ADDRESS <b>111 Penn Street</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>11/3/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Co.</b> STATE <b>MD</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 30 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 4 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |  |  |   |                         |
|--|---|--|--|---|-------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>F/Mr Alonzo Peters</b>  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>10/31/80</b>               |   | 2b. HOUR <b>11 A.M.</b> |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>8 4 11</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>                      | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |                         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City MD.</b> |   |                         |
| 10. CITY OR TOWN OF DEATH <b>Balt</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secours Hosp.</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baby Shop</b>   | 12b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMP.</b>             |   |                         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b> 13c. COUNTY <b>Howard</b> |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS <b>311 W. Spring Dr.</b>                   |   |                         |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>William Alonzo Peters</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Fallon</b>   |  |   |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>   |   | 16b. SOCIAL SECURITY NO. <b>111-11-1111</b>  | 17. INFORMANT <b>Edis Chart.</b>                               |   |                         |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Morose Upon Evidently Escapable.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ch. of Esophagus</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |   |  |   |
|---|---|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:30 PM 10 31 1980</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) move the body after death. |   |  |   |
| 22b. SIGNATURE <b>Robert M.D.</b>   | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert M.D.</b>  | 22e. ADDRESS <b>Bon Secours.</b>  |  |   |

|   |                          |  |   |
|---|--------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> | 23b. DATE <b>11/3/80</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd Cem.</b> | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Ellicott City Howard, Maryland</b> |
|---|--------------------------|--|---|

|   |  |   |
|---|--|---|
| 24. FUNERAL DIRECTOR <b>Black Funeral Home Ellicott City, Md. 21043</b> | 25a. REC'D. BY REGISTRAR <b>NOV 6 1980</b> | 25b. REGISTRAR'S SIGNATURE <b>Robert M.D.</b> |
|---|--|---|



NOV 6 1980  
U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
SALT LAKE CITY, UTAH

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |   |  |   |   |   |   |   |
|--|-------------------------|---|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John E. Peterson</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 10 17 19 80 |   |   | 2b. HOUR<br>5:10 P.M.   |   |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8-5-1956</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>24 YRS.</b>                                 | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>10 17 19 80   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Minnesota</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital-S.T.U.</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B.G. &amp; E.</b> |
| 13a. STATE<br><b>Md.</b>   |                         |   | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>5614 Daybreak Terrace-21206</b>                           |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert F. Peterson</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Louise Brent</b>  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>212-70-7579</b>  |  | 17. INFORMANT<br><b>Mr. Robert F. Peterson Sr.</b> ADDRESS<br><b>5614 Daybreak Terrace 21206</b>  |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Injuries</b><br><b>8/22</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR <b>12:15</b> P.M. MONTH <b>10</b> DAY <b>17</b> YEAR <b>19 80</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject was driver of motorcycle in collision with auto</b>             |   |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Rossville Blvd. &amp; Lillian Holt Dr., Baltimore, Md.</b>  |   |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |   |   |   |
| ACTUAL SIGNATURE<br><b>Margaret A. Korell</b>  |                         | TITLE (SPECIFY)<br><b>Assistant</b>   |  | MEDICAL EXAMINER  |   | DATE SIGNED<br><b>10-18-80</b>  |   |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         | ADDRESS<br><b>111 Penn Street</b>   |  |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>10-21-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                     |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>  |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert F. Peterson</b>                             |   |   |



2

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **30 25745**

**FOR  
1- STATE  
REGISTRAR**

|  |                         |   |  |  |  |   |  |   |  |   |                  |   |  |
|--|-------------------------|---|--|--|--|---|--|---|--|---|------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                         | FIRST<br><b>Timothy</b>   |  | MIDDLE<br><b>Peterson</b>  |  | LAST<br><b>Peterson</b>   |  | 2a. DATE OF DEATH<br>KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> |  | MONTH<br><b>10</b>                            | DAY<br><b>26</b> | YEAR<br><b>1980</b>   | 7b. HOUR<br><b>10</b>                        |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>20</b> YEAR <b>49</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>31</b> YRS.  |  | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |  | 2c. DATE PRONOUNCED DEAD<br><b>10 26 1980</b> |                  | 2d. HOUR<br><b>1:29</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                     |  |   |                  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY             |                  |   |  |
| 13a. STATE<br><b>MD</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>710 N. Gilmore St.</b>  |  |   |                  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Paul</b> MIDDLE <b>Hamilton</b> LAST <b>Hamilton</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Annie</b> MIDDLE <b>Peterson</b> LAST <b>Peterson</b>  |  |  |  |   |  |   |  |   |                  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  | 17. INFORMANT ADDRESS<br><b>Paul Hamilton 942 Poplar Grove St.</b>                                   |  |   |  |   |  |   |                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>Gun shot wound of chest</b> <b>Gun: Handgun</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b).<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c).  |                         |   |  |  |  |   |  |   |  |   |                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |  |  |   |  |   |  |   |                  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |  |   |                  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12:35AM 10/26 1980</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject shot</b> |  |   |  |   |  |   |                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Doll House Bar</b>  |  | 21f. LOCATION<br>STREET<br><b>425 E. Baltimore St.</b>   |  | CITY OR TOWN<br><b>Baltimore City</b>   |  | COUNTY<br><b>MD</b>   |  | STATE   |                  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |  |  |   |  |   |  |   |                  |   |  |
| ACTUAL SIGNATURE<br><b>Hormez R. Guard</b>   |                         | TITLE (SPECIFY)<br><b>Assistant</b>   |  | M.D. <b>Assistant</b>  |  | MEDICAL EXAMINER  |  | DATE SIGNED<br><b>10/26/80</b>  |  |   |                  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street, Baltimore, MD 21201</b>  |  |  |  |   |  |   |  |   |                  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>10/30/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>                                       |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>   |  | COUNTY<br><b>Co.</b>  |  | STATE<br><b>MD</b>                            |                  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |                         | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ruby Helms</b>   |  |   |  |   |                  |   |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PGM 1b, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DPWH - 17  
(REV. 4-15-80)  
15M 7/78



Form with multiple sections and fields, mostly containing faint, illegible text. The form appears to be a document or report, possibly related to a company or organization, given the presence of the 'M' logo.

*Handwritten signature or initials.*

0887 79730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified (show 12335)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 5 7 4 6<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>PETER P PETRASKA   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 16 80   |  | 2b. HOUR<br>4 43 AM  |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>CAUC  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10 19 99   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>         |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SO. BALTO GEN HOSP |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dupont  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   |  | 13b. COUNTY<br>-----  |  | 13c. CITY OR TOWN<br>Baltimore   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>ANTHONY PETRASKA  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA DENKEVITZ   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>216 057677  |  | 17 INFORMANT ADDRESS<br>MARIE PETRASKA 405 JACK STREET  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PULMONARY EMBOLISM<br>1519 DUE TO, OR AS A CONSEQUENCE OF<br>(b) DEEP VEIN THROMBOSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) ADENOCARCINOMA OF STOMACH                          |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 hours<br>18 days<br>2 months  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 09/29 19 80, to 10/16/ 19 80, that (I) (we) last saw the deceased alive on 10/16 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>G.L. Wergowske   |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/16/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>G.L. Wergowske  |  |   |  | 22e. ADDRESS<br>3001 S. Hanover St.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/20/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Cross Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Anne Arundel Maryland  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br>Mc Cully Funeral Home 87 Brooklyn<br>237 E. Patapsco Avenue Baltimore, Md. 21225  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>OCT 17 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Randy Kelley   |  |

RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

*[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

REG. NO.

2 5 7 4 7

|   |  |   |  |   |   |   |   |                                   |  |  |  |
|---|--|---|--|---|---|---|---|-----------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | 2a. DATE OF DEATH  |   |   | MONTH DAY YEAR  |   |                                   | 2b. HOUR   |  |  |
| LILLIAN C. PFEIFER  |  |   | 10-25-80   |   |   | 7:25A   |   |                                   |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS                              |  |
| FEMALE  |  | WHITE   |  | 12 02 1899  |   | 80 YRS.   |   | MONTHS DAYS                       |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |                                   |  |  |  |
| MARYLAND  |  | U.S.A.  |  |   |   | BALTIMORE CITY MD.  |   |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| BALTIMORE   |  | ST AGNES HOSPITAL   |  |   |   | SECRETARY   |   | GENERAL                           |  |  |  |
| 13a. STATE  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN                         |   | 13d. INSIDE CITY LIMITS?  |                                   |  |  |  |
| MARYLAND  |  |   | BALTIMORE  |   | HALETHORPE                                |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |  |  |
| 14. FATHER'S NAME   |  |   | 15. MOTHER'S MAIDEN NAME   |   |   | 16. STREET ADDRESS  |   |                                   |  |  |  |
| FIRST MIDDLE LAST   |  |   | FIRST MIDDLE LAST  |   |   | ELECTRIC  |   |                                   |  |  |  |
| GEORGE J. HUBER   |  |   | MARY   |   |   | 4503 POPLAR AVENUE, 21227   |   |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |   | 17. INFORMANT ADDRESS                     |   |   |                                   |  |  |  |
| NO  |  |   | 216-05-3474  |   | W. EDWARD PFEIFER, SR. 4503 POPLAR AVENUE |   |   |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  |   |   |   |   |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |   |   |   |                                   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?   |   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |   |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |                                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 23</u> , 19 <u>80</u> , to <u>OCT 25</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>OCT 2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |   |                                   |  |  |  |
| 22b. SIGNATURE  |  |   | DEGREE   |   |   | 22c. DATE SIGNED  |   |                                   |  |  |  |
| <u>Oscar Hernandez</u>  |  |   | M.D.   |   |   | 10-25-80  |   |                                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   | 22e. ADDRESS   |   |   |   |   |                                   |  |  |  |
| Oscar Hernandez   |  |   | 900 CATON AVE. BALTIMORE MD 21229                                      |   |   |   |   |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                   |  |  |  |
| BURIAL  |  |   | 10-28-80   |   | LOUDON PARK                               |   | BALTIMORE CITY MARYLAND   |                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   | 24b. ADDRESS   |   |   | 25a. DATE REC'D. BY REGISTRAR   |   |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |  |
| HUBBARD FUNERAL HOME, INC.  |  |   | 4107 WILKENS AVE.  |   |   | OCT 27 1980   |   |                                   | <u>[Signature]</u>   |  |  |

(M)

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

10

2

OCT 2 1980



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

25748

REG. NO.

|   |  |   |   |   |  |   |   |   |   |  |
|---|--|---|---|---|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Leo John Philip</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-25-80</b>                  |   |  | 2b. HOUR<br><b>11:10 P.M.</b>   |   |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 23, 1915</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                     |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor Social Security</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                    |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>4408 Marx Ave</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John S Philip</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Santo</b>   |  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>NW 11</b> |   | 17. INFORMANT<br><b>Virginia A Philip</b>                |   | ADDRESS<br><b>Same</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK &amp; ANOXIC ENCEPHALOPATHY</b><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ISCHEMIA + OAMI leading to Cardio Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>28 hrs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>          |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>            |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>N/A</b>          |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/24/80</b> to <b>10/25/80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/25/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (do not) view the body after death.  |  |   |   |   |  |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Harleen Grewal MD</b>  |  |   |   |   |  | 22c. DATE SIGNED<br><b>10/25/80</b>   |   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARLEEN GREWAL</b>  |  |   |   |   |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>10/29/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey, Maryland</b>                           |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |   |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Harry H. H. H.</b>   |   |  |

MEDICAL CERTIFICATION

James M. Smith

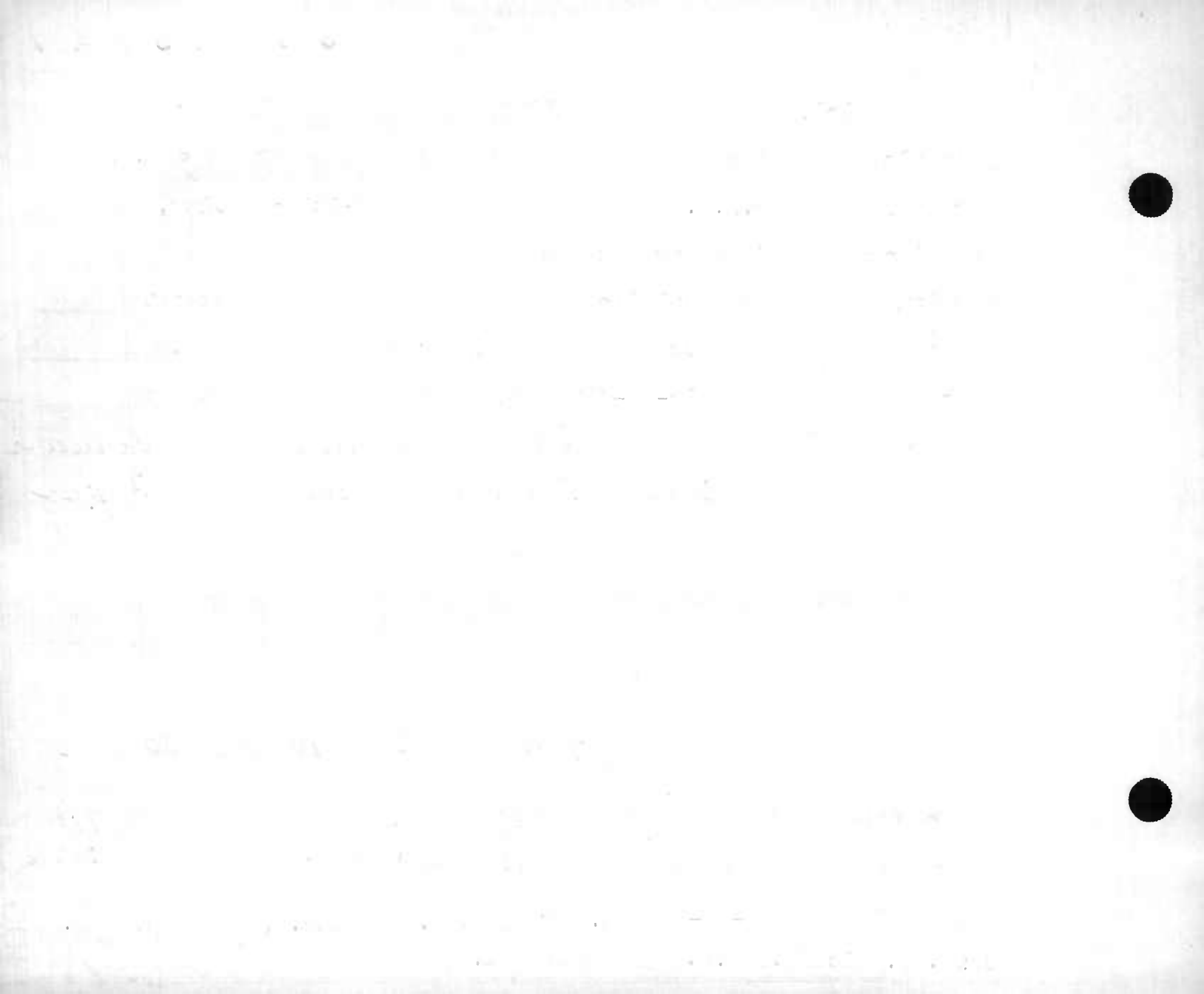
TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 5 7 4 9<br>REG. NO.   |   |   |  |   |                                    |
|---|--|---|--|---|---|---|--|---|------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Viola Phillip   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 5 80  |   |   |  | 2b. HOUR<br>M                             |                                    |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 3 03  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                          |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>5 3     | IF UNDER 24 HRS<br>HOURS MIN.<br>1 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.         |  |   |                                    |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1427 Ward Street |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY         |                                    |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br>1427 Ward Street                             |  |   |                                    |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Creek   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth Creek  |   |   |  |   |                                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>212-05-8190   |   | 17. INFORMANT<br>ADDRESS<br>Irene Creek 1427 Ward Street            |  |   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>436 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>2 year</u> |  |   |  |   |   |   |  |   |                                    |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |   |   |  |   |                                    |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |   |                                    |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> , 19 <u>52</u> , to <u>10-5</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>10-1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |   |                                    |
| 22b. SIGNATURE<br>John P. Urlock Jr   |  |   |  | DEGREE<br>M.D.  |   |   |  | 22c. DATE SIGNED<br>10/7/80               |                                    |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN P. URLOCK JR MD   |  |   |  | 22e. ADDRESS<br>1227 WASHINGTON BLVD 21230  |   |   |  |   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10-10-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. (Westport) Md. |  |   |                                    |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chas. A. Rice F.S.P.A.  |  |   |  | ADDRESS<br>1300 Eutaw Pl.   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 8 1980                         |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |                                    |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

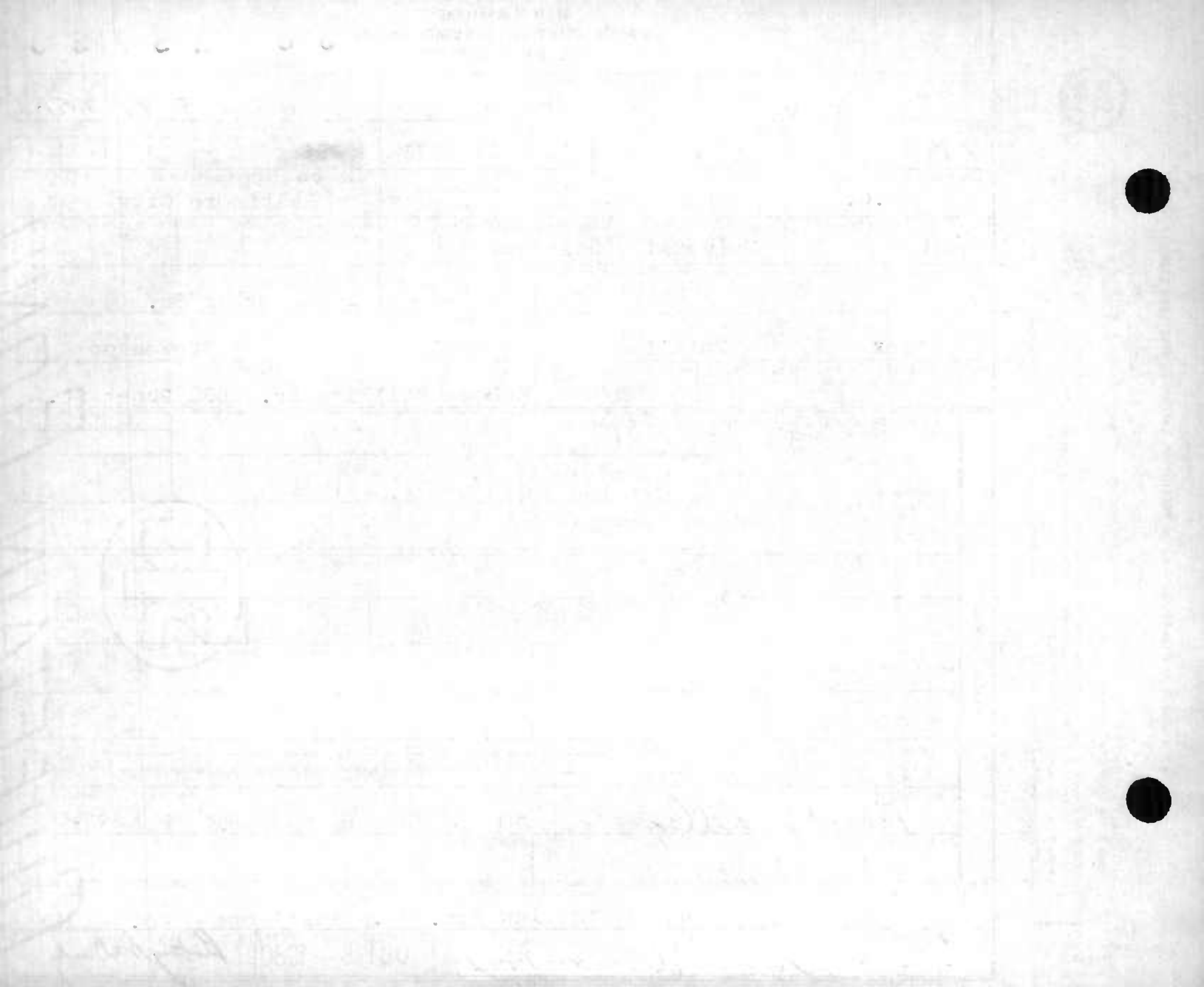
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |                                   | 8025750  |  |
|--|--|--|--|---|--|--|--|--|-----------------------------------|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |                                   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Hubert Phillips  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 5 80                            |  |  | 2b. HOUR<br>2:15 A.M.             |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 11 23  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | 7. IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br>MD   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                   | 13e. STREET ADDRESS<br>1026 Mosher St.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Essex Phillips   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Leola Stevenson  |  |  |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |  | 17. INFORMANT ADDRESS<br>Robert Phillips Sr. 2633 Puget St.                    |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-pulmonary arrest<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic Adenocarcinoma of the Lung<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |                                   |  |  |
| 22b. SIGNATURE<br>David E. Kelley  |  |  |  | DEGREE<br>MD  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br>10/5/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David E. Kelley   |  |  |  | 22e. ADDRESS  |  |  |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>10/13/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>Wm. C. March F/H 1101 E. North Ave.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1980                                    |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                                   |  |  |

MEDICAL CERTIFICATION



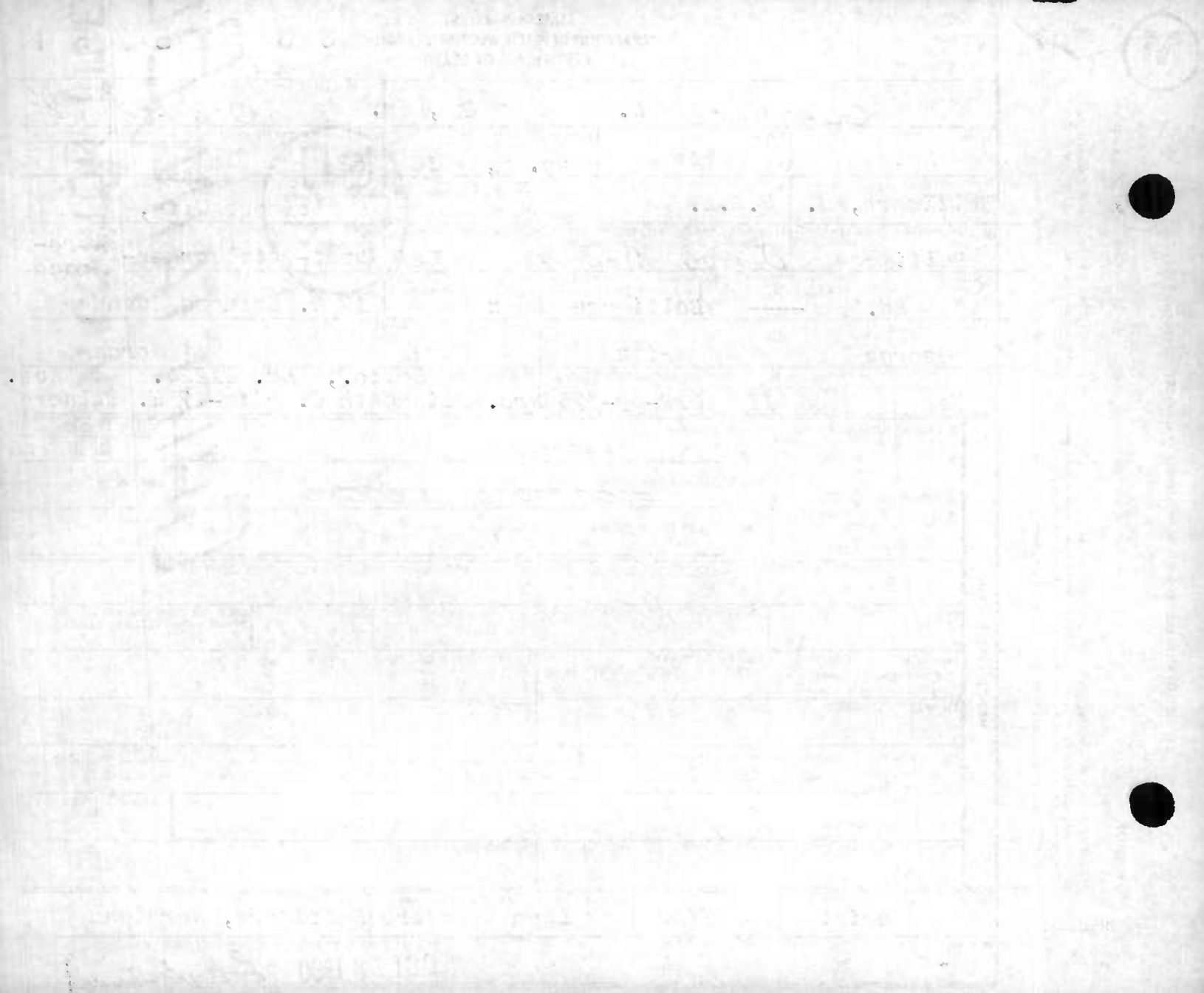
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 80 25751   |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>CLARENCE L. PITZ, Sr.</i>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10-24-80</i>  |  | 2b. HOUR<br><i>8:00 M</i>   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Aug. 5, 1918</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><i>62</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City, MD.</i>  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Deaton Medical Center</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Sheet-metal Worker</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Aero-Space</i>  |  |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>---</i>  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><i>17 N. Belnord Avenue</i>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>George Pitiz</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mary Moran</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>Yes</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>WW II 121-09-3758</i>   |  | 17. INFORMANT<br><i>Balto., Md. 21224. Mrs. Elizabeth C. Pitz-17 N. Belnord Ave.</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>sepsis</i><br>7184<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>fractured rib</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>CONTRACTURES</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 WEEKS</i><br><i>MOS.</i><br><i>MOS.</i> |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>PARKINSONS</i>  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-28</i> , 19 <i>80</i> , to <i>9-24</i> , 19 <i>80</i> , that (I/we) lost <i>saw the deceased alive above, (I) (we) (did) (and not view the body after death.</i> <i>10-21</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |  |  |  |  |   |  |
| 22b. SIGNATURE <i>John S. Moran M.D.</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN S. MORAN</i>   |  |  |  | 22e. ADDRESS <i>107 E WEST ST.</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |  | 23b. DATE <i>10/27/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>  |  |
| 24. FUNERAL DIRECTOR NAME <i>John E. Moran, Inc.</i> ADDRESS <i>3000 E. Baltimore St.</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>OCT 28 1980</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Henry K. Brown</i>  |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 / 5 2

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MATILDA POGORILICH</b> |  |   | 2g. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-6-80</b> |   |  | 2h. HOUR<br><b>7:05 PM</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 1 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>YUGOSLAVIA</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHN L. DEATON MEDICAL CENTER</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  |
| 13a. STATE<br><b>NEW JERSEY</b>   |  | 13b. COUNTY<br><b>CAMDEN</b>  |   | 13c. CITY OR TOWN<br><b>WESTMONT</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>     |  | 16b. SOCIAL SECURITY NO.<br><b>139-05-9019</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>GLENDORA, N.J.</b>   |  |  |  |
| 17. INFORMANT<br>ADDRESS<br><b>GLENDORA, N.J.</b>                                     |  | 18. INFORMANT<br>ADDRESS<br><b>JOSEPH POGORILICH 49 LILLIAN PLACE</b>   |   |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) **DEATH TATION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ATHEROSCLEROTIC CARDIOVASCULAR DISEASE**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**1 DAY****YEARS****YEARS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |

22a. I certify that (I) (this hospital) attended the deceased from **6-24**, 19 **80**, to **10-6**, 19 **80**, that (I) (we) lost  
saw the deceased alive on **10-6**, 19 **80**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 22b. SIGNATURE<br><b>CHRISTINE L. COMMERCIAL</b>                        |  | DEGREE<br><b>NO</b>                                  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>OCT 7, 1980</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHRISTINE L. COMMERCIAL</b> |  | 22e. ADDRESS<br><b>JOHN L. DEATON MEDICAL CENTER</b> |  |  |  |  |  |

|   |  |                              |  |   |  |  |  |
|---|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>REMOVAL/BURIAL</b> |  | 23b. DATE<br><b>10-09-80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. JOSEPH'S</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CHEWS LANDING CAMDEN N.J.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>BALTIMORE, MD. 21229</b>           |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 7 1980</b>        |  | 25b. REGISTRAR'S SIGNATURE<br><b>Fitzroy</b>                                   |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.                          |  |                              |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

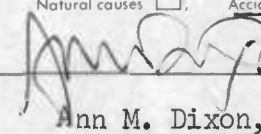



UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT SHOULD BE EXECUTED WITHIN 72 HOURS. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5. IF YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |   |  |   |  |  |  |  |                         | REG. NO. 25753 |  |
|--|----------------------|---|--|---|--|--|--|--|-------------------------|----------------|--|
| 1- FOR STATE REGISTRAR<br>DECEASED NAME (TYPE OR PRINT) <b>BYRON JACK POLING</b>   |                      |   |  |   |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <b>10</b> DAY <b>16</b> YEAR <b>80</b> |  | 2b. HOUR <b>8:40</b> AM |                |  |
| 3. SEX <b>male</b>   | 4. RACE <b>white</b> | 5. DATE OF BIRTH MONTH <b>1</b> DAY <b>1</b> YEAR <b>60</b>   | 6. AGE (IN YEARS) (LAST BIRTHDAY) <b>20</b> YRS. | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>  | IF UNDER 24 HRS. HOURS <b></b> MIN <b></b> | 7c. DATE PRONOUNCED DEAD MONTH <b>10</b> DAY <b>16</b> YEAR <b>80</b>  |  | 7d. HOUR <b>a</b> AM   |                         |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Separated</b>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |  |                         |                |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Johns Hopkins Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>                                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>                                       |                         |                |  |
| 13a. STATE <b>Maryland</b>   |                      | 13b. COUNTY <b>-</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS <b>1144 Quantril Way, 21205</b>                              |                         |                |  |
| 14. FATHER'S NAME FIRST <b>Loman</b> MIDDLE <b>-</b> LAST <b>Poling</b>  |                      |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Jean</b> MIDDLE <b>-</b> LAST <b>Anderson</b>   |  |  |  |  |                         |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |                      | 16b. SOCIAL SECURITY NO. <b>216-74-4935</b>   |  | 17. INFORMANT ADDRESS <b>Mrs. Jean Poling, mother, same address</b>   |  |  |  |  |                         |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cranio-cerebral trauma</b><br><b>8/22</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |                      |   |  |   |  |  |  |  |                         |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |                      |   |  |   |  |  |  |  |                         |                |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                         |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>2:32 P.M. 10-15-80</b>   |                      | 21b. TIME OF INJURY HOUR <b>2:32</b> MONTH <b>10</b> DAY <b>15</b> YEAR <b>80</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Operator of motorcycle/auto collision.</b>       |  |  |  |  |                         |                |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>   |  | 21f. LOCATION STREET <b>Balto. &amp; Chester Sts., Balto.</b> CITY OR TOWN <b>Balto.</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b> |  |  |  |  |                         |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |   |  |   |  |  |  |  |                         |                |  |
| ACTUAL SIGNATURE    |                      | TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>10-16-80</b>  |  |  |                         |                |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |                      | ADDRESS <b>111 Penn St.</b>   |  |   |  |  |  |  |                         |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>10/20/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>                             |  |  |                         |                |  |
| 24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> ADDRESS <b>3331 Brehms Lane Balto., Md. 21213</b>   |                      |   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                         |                |  |



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1001 18 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 5 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |  |   |  |                                      |  |
|--|--|--|--|--|--|--|---|--|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SARAH   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 6, 1980                 |  |  | 2b. HOUR<br>M  |   |  |                                      |  |
| 3 SEX<br>Female  |  | 4 RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 15 94   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>86   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>YRS   |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |                                      |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>441 Watty Ct. |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                                      |  |
| 13a. STATE<br>MD   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>441 Watty Ct. |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Spivey  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>— — —                  |  |  |  |   |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>N/A          |  | 17 INFORMANT<br>ADDRESS<br>Joan Foy 2827 Hilldale Ave. |  |   |  |                                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cerebral Paralysis</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension and Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Cardiovascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |   |  |                                      |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> 19 <u>70</u> to <u>Aug</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |   |  |                                      |  |
| 22b. SIGNATURE<br><u>Virginia L. McDonald, M.D.</u>  |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>10-7-80  |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VIRGINIA L. MCDONALD, M.D.  |  |  |  |  |  | 22e. ADDRESS<br>P.O. Box 16439 Baltimore, MD # 21217   |   |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>10/11/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD                                  |  |                                      |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  |  |  |  |  | ADDRESS<br>1101 E. North Ave.  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 7 1980  |                                      |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey K. Brady</u>  |  |  |  |  |  |  |   |  |                                      |  |



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OUT 5 1980

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 7

5 5

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Pomerantz</i> <b>YETTA</b> <i>Yetta</i> <b>POMERANTZ</b>                                    |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10/31/80</i>  |  | 2b. HOUR<br><i>12:05 AM</i>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN. 15, 1895</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>85</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Sizai Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. CITY OR TOWN<br><b>BALTO.</b>  |  | 13c. STREET ADDRESS<br><b>APT. 3-A</b><br><b>3401 VARGAS CIR. #21207</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MAYER</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>EVA MEYERS</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-10-4358D</b>   |  | 17. INFORMANT<br><b>MRS. SYLVIA GOLDBERG</b><br><b>3401 VARGAS CIR., APT. 3A #21207</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardio respiratory arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>renal failure, anemia, pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>SCLA</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Manuel A. Martin</i>   |  | DEGREE<br><i>MD</i>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br><i>10/31/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Manuel A. Martin</i>  |  | 22e. ADDRESS<br><i>Sizai Hospital</i>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>NOV. 2, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OHEL YAKOV</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS<br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. ...</i>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>THOMAS I. POTE  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 17 80                        |   |  | 2b. HOUR<br>2:30 P.M.   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-13-1882  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>98 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cabinet Maker               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retired   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4113 Marx Avenue-21206  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Henry Potee  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Catherine Bentley             |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-03-9713   |  | 17. INFORMANT ADDRESS<br>Mrs. Elsa M. Potee 4113 Marx Ave.-21206  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pneumonia<br>486 -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 weeks |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1/80 to 10/17/80, that (I) (we) last saw the deceased alive on 10/17/80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (all) did not view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Stuart B. Bell MD  |  |  |  |   | 22c. DATE SIGNED<br>10/17/80   |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STUART B. BELL MD   |  |
| 22e. ADDRESS<br>3501 St. Paul #144   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>10-20-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cmn.                            |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.-21206 |  |  |
| 24. FUNERAL DIRECTOR<br>John C. Miller Inc-6415 Belair Rd.-21206   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 20 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

10-1-1992

at first order

11/10/92 (11/10/92)

at first order

1-1-1992 (1-1-1992)

OCT 20 1992

10-1-1992

10-1-1992

initial

10-1-1992

10-1-1992

10-1-1992

*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.


 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 0

2 5 1 5 1

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(Type or print) <b>Ernest J. Potter</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/7/80</b>                                   |  | 2b. HOUR<br><b>5 am</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 3 1931</b>   |   | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>KY</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Deaton Medical Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Howard Johnson</b>   |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Owings Mills</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          | 13e. STREET ADDRESS<br><b>124 Fernington Circle</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Thomas Potter</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ballenger</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>404-44-0515</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Miss Thelma Potter</b><br><b>4509 N. Rogers Ave., Baltimore, MD 21215</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BILATERAL CVA</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b><br><b>1 WEEK</b><br><b>1 MONTH</b>                           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-25</b> , 19 <b>80</b> , to <b>10-7</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-6</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.            |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Marcel S. Power M.D.</b>  |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>10/7/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARCEL S. POWER M.D.</b>   |   | 22e. ADDRESS<br><b>107 E. WEST ST.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>10/10/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cemetery</b>                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Randallstown Baltimore MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, P.A.</b><br>ADDRESS <b>8728 Liberty Rd., Randallstown, MD 21133</b>  |   |   | 25a. DATE RECD. BY REGISTRAR<br><b>OCT 14 1980</b>                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |  |  |                                      |  |   |  | REG. NO. 25758                               |  |
|--|---------|--|--|--|--|--------------------------------------|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |         | FIRST  |  | MIDDLE   |  | LAST                                 |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | Charles  |  | W.   |  | Powell                               |  | ESTIMATED <input checked="" type="checkbox"/> 10 18 80                        |  | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.                       |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD                     |  |
| male   | negro   | 6 16 97  |  | 83   |  | MONTHS DAYS                          |  | HOURS MIN.  |  | 10 21 80                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |  |  |
| MD   |         | USA  |  | Baltimore City MD  |  |                                      |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |  |  |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Baltimore  |         | 2540 W. Lombard St.                                      |  |  |  |                                      |  |   |  |  |  |
| 13a. STATE   |         |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                    |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |
| MD   |         |  |  |  |  | Baltimore                            |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 2540 West Lombard St.                        |  |
| 14. FATHER'S NAME  |         |  |  | 15. MOTHER'S MAIDEN NAME   |  |                                      |  |   |  |  |  |
| FIRST MIDDLE LAST  |         |  |  | FIRST MIDDLE LAST  |  |                                      |  |   |  |  |  |
| Charles Powell   |         |  |  | Carrie   |  |                                      |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                |  |   |  |  |  |
| No   |         |  |  | 218-01-2405  |  | Mary Elizabeth Tunstall 1820 E. Cha  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |  |  |                                      |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1 DEATH WAS CAUSED BY:  |         |  |  |  |  |                                      |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |         |  |  |  |  |                                      |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |                                      |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |  |  |                                      |  |   |  |  |  |
| (b)  |         |  |  |  |  |                                      |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |  |                                      |  |   |  |  |  |
| (c)  |         |  |  |  |  |                                      |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |  |  |                                      |  |   |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                      |  |   |  |  |  |
|  |         |  |  |  |  |                                      |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |
|  |         |  |  | P.M. 19  |  |                                      |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |
|  |         |  |  |  |  |                                      |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |  |  |                                      |  |   |  |  |  |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)  |  |                                      |  | DATE SIGNED   |  |  |  |
| Virginia L. Dolan  |         |  |  | Assistant  |  |                                      |  | 10-22-80  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS  |  |                                      |  |   |  |  |  |
| Virginia L. Dolan, M.D.  |         |  |  | 111 Penn St.   |  |                                      |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN           |  | COUNTY  |  | STATE  |  |
| Burial   |         | 10/29/80   |  | Baltimore Cemetery   |  | Baltimore                            |  |   |  | MD   |  |
| 24. FUNERAL DIRECTOR NAME  |         |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |                                      |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Wm. C. March F/H   |         |  |  | 1101 E. North Ave. OCT 29 1980   |  |                                      |  | [Signature]   |  |  |  |

UNITED STATES DEPARTMENT OF THE ARMY  
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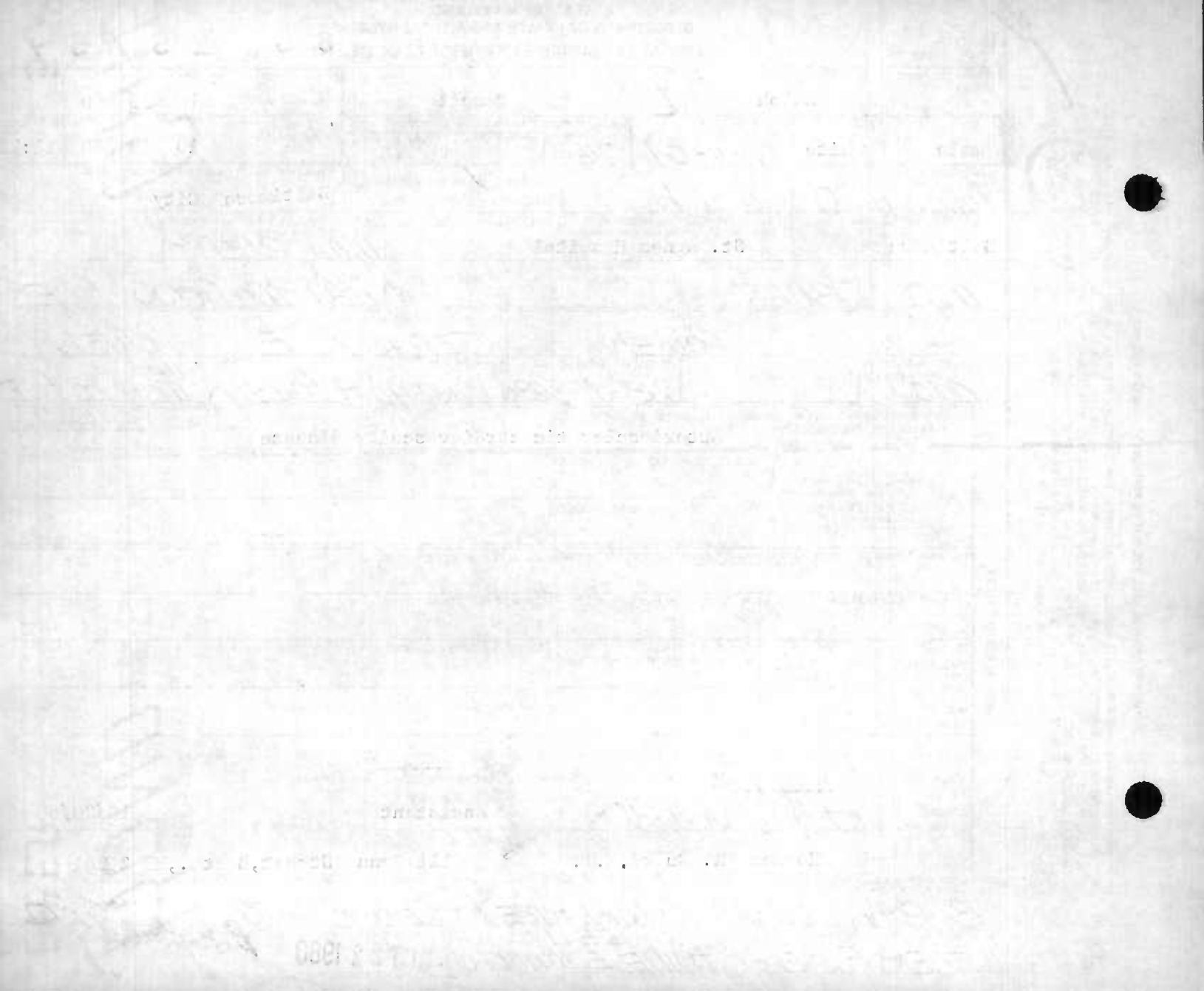
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 25759

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ralph L Powell</b>   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>10 19 80</b>  |  |  |  | 2b. HOUR<br>M<br><b>PM</b>  |  |
| SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-11-04</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>76</b> YRS.                               |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MAIL CLERK</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1121 McADOO AVE</b>                                      |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Abner Powel</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETHEL E Powel</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>N/O</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-09-3630</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>1121 McADOO AVE</b>                                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)      |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>J. S. Guard</b>   |  |   |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |  |  | DATE SIGNED<br><b>10/20/80</b>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  |   |  | ADDRESS<br><b>111 Penn Street, Balto., MD 21201</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-23-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORENAIRE P.C. CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTO. MD</b>                           |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WEBER FUNERAL HOME</b>  |  |   |  | ADDRESS<br><b>EDMONTON</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1980</b>                                |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| 1. FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | REG. NO. 80 25760   |   |
|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Arthur B Prem   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 14 80  |   | 2b. HOUR<br>4:30 PM   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 30 94   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Balto.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Ret. Linotype San Papers |   | 12b. KIND OF BUSINESS OR INDUSTRY                           |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2805 Shirey Avenue                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frank X. Prem   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Hanson   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-03-2126  |  | 17. INFORMANT<br>ADDRESS<br>Mr. Robert C. Prem 929 N. Howard St.                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Failure to Eat<br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) FAR ADVANCED CA OF PROSTATE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |   |
| 19a. DATE OF OPERATION<br>9/15/80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CHOLELITHIASIS ING. HERMA   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/12, 1980, to 10/14, 1980, that (I) (we) lost<br>saw the deceased alive on 10/14, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br>Rogelio A. Filamor  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>10/14/80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROGELIO A. FILAMOR   |  | 22e. ADDRESS<br>GOOD SAM  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>Oct. 17, 1980  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leonard J. Ruck Inc. Baltimore, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT. 5 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. Ruck  |   |

0002800



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                    |  |  | 80 25761   |  |  |   |
|--|--------------------|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR   |                    |  |  | REG. NO.   |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CARRIE D PRICE</b>  |                    |  |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>13</b> YEAR <b>80</b>  |  | 2b. HOUR<br><b>11:20</b> AM  |   |
| 3 SEX<br><b>F</b>  | 4 RACE<br><b>N</b> | 5 DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>24</b> YEAR <b>24</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>   |                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |   |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |                    | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH CASES, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                    |  |  | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13b. STREET ADDRESS<br><b>2820 Frederick Avenue</b>  |   |
| 13a. STATE<br><b>Md.</b>   |                    | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN  |  |  |   |
| 14 FATHER'S NAME<br>FIRST <b>Willie</b> MIDDLE <b>Henderson</b> LAST <b></b>   |                    |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Jessie</b> MIDDLE <b>Youngs</b> LAST <b></b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |                    | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>249-44-3872</b>   |  | 17 INFORMANT<br><b>Jessie Price</b>  |  | ADDRESS<br><b>1205 W. Mosher St.</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C.V.A. and cerebral edema</b><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                    |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Ischaemic heart disease Hypertension</b>  |                    |  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |                    | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                    | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                    | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10. 11.</b> 19 <b>80</b> , to <b>10. 13.</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10. 13.</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |                    |  |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Vijay Narayan</b>   |                    |  |  | DEGREE<br><b></b>  |  | 22c. DATE SIGNED<br><b>10.13.80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. VIJAY NARAYEN</b>  |                    |  |  | 22e. ADDRESS<br><b>900 CATON AVE. BALTIMORE, MD. 21229</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                    | 23b. DATE<br><b>10/17/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Church Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Newberry</b> COUNTY <b></b> STATE <b></b>   |   |
| 24 FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E North Ave</b>  |                    |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |  | 25b. SIGNATURE<br><b>Vijay Narayan</b>   |   |

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHHM-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 6 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MOLLIE GAINE PUKETZ</b>  |  |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>18</b> YEAR <b>1980</b> 2b. HOUR <b>4:30</b> AM                      |  |   |
| 3 SEX<br><b>FEMALE</b>  | 4 RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH MONTH <b>APRIL</b> DAY <b>30</b> YEAR <b>1898</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 7. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>HUNGARY</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                 |   |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINDALE GERIATRIC CENTER</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESLADY</b>                                |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>3455 SHOP</b>  |
| 13a. STATE <b>MD</b>  | 13b. COUNTY <b>---</b>   | 13c. CITY OR TOWN <b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  | 13e. STREET ADDRESS <b>5715 PARK HEIGHTS AVENUE</b>                            |   |
| 14. FATHER'S NAME FIRST <b>HIRSCH</b> MIDDLE <b>MEINDEL</b> LAST <b>SCHWARTZ</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>HELEN</b> MIDDLE <b>UNKNOWN</b> LAST <b>---</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO <b>127-14-9235</b>   |   | 17. INFORMANT ADDRESS <b>21398</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b><br><b>436-</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>COMATOSE STATE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBROVASCULAR ACCIDENT</b> |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):   |  |  |   |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/10</b> 19 <b>75</b> to <b>10/18</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/18</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |   |
| 22b. SIGNATURE <b>[Signature]</b>   |  | DEGREE   |   | 22c. DATE SIGNED <b>10/18/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. ZAW - WIN</b>   |  | 22e. ADDRESS <b>LEVINDALE GERIATRIC CENTRE</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>OCT 19, 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW RESTORATION</b> MD.     |   |
| 24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; SONS INC</b> ADDRESS <b>6010 RISTERSDOWN RD</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 22 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                  |   |

WILLIS PAINE PRICATE

10/15/80 42

LEAVE DATE 10/15/80

REASON FOR LEAVE

PERSONAL BUSINESS

10/15/80 - 10/15/80

RESIGNATION

REASON FOR LEAVE

10/18 12/10 12/10/80

10/18/80

REASON FOR LEAVE

10/18/80

REASON FOR LEAVE

REASON FOR LEAVE

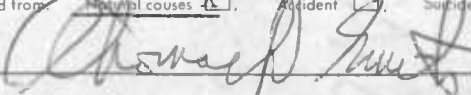
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>James   |  |  | MIDDLE<br>A.  |  |  | LAST<br>Quigley   |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR |  |  | 2b. HOUR   |  |  |   |  |  |  |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 3, 1900   |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>80 YRS.   |  |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10 16 1980 |  |  | 7d. HOUR<br>P<br>M  |  |  |  |  |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4206 Roland Avenue |  |  |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK                          |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETIRED.   |  |  |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br>MD.   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN<br>BALTO.   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>4206 ROLAND AVE.   |  |  |  |  |  |   |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWARD V. QUIGLEY   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ELLA F. CULLEN   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>YES   WWI   |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-07-5829   |  |  |   |  |  | 17. INFORMANT<br>ADDRESS<br>MRS. NORRIS SANBURY 31 SOUTH AUGUSTA AVE.                   |  |  |  |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |  |  |  |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)           |  |  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>   |  |  |  |  |  | TITLE (SPECIFY)<br>Deputy Chief, MEDICAL EXAMINER   |  |  |   |  |  | DATE SIGNED<br>10/17/80   |  |  |  |  |  |   |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |  |  |  |  | ADDRESS<br>111 Penn St. Balto., MD.   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |  |  |  |  | 23b. DATE<br>10-20-80   |  |  |   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NEW CATH. CEM.                                    |  |  |  |  |  | 23d. LOCATION<br>TOWN COUNTY<br>BALTO. MD.  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>FARLEY F.H.   |  |  |  |  |  | ADDRESS<br>6601 FRED. AVE.  |  |  |   |  |  | DATE OF DEATH<br>OCT 22 1980  |  |  |  |  |  | REGISTERAR'S SIGNATURE<br> |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/77

| FOR<br>1- STATE REGISTRAR   |  |                  |  |   |  |  |  |                               |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |                     |  |  |  |  |  | REG. NO. 25764          |  |          |  |
|---|--|------------------|--|---|--|--|--|-------------------------------|--|--|--|--|--|---------------------|--|--|--|--|--|-------------------------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  |  |   | FIRST<br>MORRIS  |  |  |                               |  | MIDDLE<br>RABINOWITZ   |  |  |  |                     | LAST<br>RABINOWITZ   |  |  |  |  | 2a. DATE KNOWN OF DEATH |  | 2b. HOUR |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAR. 16, 1922 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10 17 80 |  | 2d. HOUR<br>2:25 PM |  |  |  |  |  |                         |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  |                  |  |   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |                               |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |  |  |  |                         |  |          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                  |  |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3923 Clarks Lane Apt. D |  |  |                               |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ELEVATOR OPERATOR   |  |  |  |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>CITY OF BALTO   |  |  |  |  |                         |  |          |  |
| 13a. STATE<br>MARYLAND  |  |                  |  |   | 13b. COUNTY<br>BALTIMORE   |  |  |                               |  | 13d. INSIDE CITY LIMITS?<br>YES XXX NO <input type="checkbox"/>  |  |  |  |                     | 13e. STREET ADDRESS<br>3923 CLARKS LA., APT. D #21215  |  |  |  |  |                         |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JACOB RABINOWITZ  |  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>REBECCA HENDIN  |  |  |                               |  |  |  |  |  |                     |  |  |  |  |  |                         |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>NO  |  |                  |  |   | 16b. SOCIAL SECURITY NO.<br>215-12-2657  |  |  |                               |  | 17. INFORMANT<br>ABRAHAM RABINOWITZ<br>6616 CHIPPEWA DR. BALTO., MD 21209  |  |  |  |                     |  |  |  |  |  |                         |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>4029 IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>disease and fatty liver.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |   |  |  |  |                               |  |  |  |  |  |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                         |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                  |  |   |  |  |  |                               |  |  |  |  |  |                     |  |  |  |  |  |                         |  |          |  |
| 19a. DATE OF OPERATION  |  |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |                               |  |  |  |  |  |                     | 20. AUTOPSY?<br>(body only)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                         |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |                               |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |                     |  |  |  |  |  |                         |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |                               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |                     |  |  |  |  |  |                         |  |          |  |
| 22a. I certify that I took charge of the remains described above, held in (body only) <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |  |   |  |  |  |                               |  |  |  |  |  |                     |  |  |  |  |  |                         |  |          |  |
| ACTUAL SIGNATURE<br><u>Margarita A. Korell</u>  |  |                  |  |   | TITLE (SPECIFY)<br>Assistant   |  |  |                               |  | DATE SIGNED<br>10-18-80  |  |  |  |                     |  |  |  |  |  |                         |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  |                  |  |   | ADDRESS<br>111 Penn Street   |  |  |                               |  |  |  |  |  |                     |  |  |  |  |  |                         |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  |                  |  |   | 23b. DATE<br>OCT. 19, 1980   |  |  |                               |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW ORTHODOX MEM. SOC.  |  |  |  |                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND                                   |  |  |  |  |                         |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |                  |  |   | 25a. DATE REC'D BY REGISTRAR<br>OCT 22 1980  |  |  |                               |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |                     |  |  |  |  |  |                         |  |          |  |

1994, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

$$(y_1, y_2)$$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 7. DATE OF DEATH   |  | MONTH DAY YEAR   |  | 2b. HOUR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                       |  |
| BABY GIRL RANDOLPH  |  | F  |  | N  |  | 10/12/80   |  | 10/15/80 4:30 am                                      |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |   |  |
| MD  |  | U.S.A.   |  |  |  | Balto. city  |  | MD  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |   |  |
| Baltimore   |  | St. Agnes Hospital   |  |  |  |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS                                   |  |
| MD  |  | Frederick  |  | Frederick  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 150 Key Pkwy.   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT   |  |
| William Bell, Jr.   |  | Darlene F. Randolph  |  | No   |  |  |  | Barbara Bell 12722 Sesame Court Germantown, Md. 20767 |  |
| 18. CAUSE OF DEATH  |  | PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |
| 7762  |  | Cardio-respiratory failure   |  |  |  | Palpitations   |  | 27 min.   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | Disseminated Intravascular Coagulation   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 10.13.80 to 14.80   |  | Disseminated Intravascular Coagulation   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN   |  | COUNTY STATE  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10.12.1980 to 10.15.1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |   |  |
| Chanelene Cheltzie  |  | MD   |  | 10.15.80   |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |
| CHANDANA CHATTERJEE   |  | SAH  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | COUNTY STATE  |  |
| Burial  |  | 10-18-80   |  | Emory Grove Cemetery   |  | Gaithersburg, Montg. Md.                                       |  |   |  |
| 24. FUNERAL DIRECTOR  |  | 24b. NAME  |  | 24c. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR                                  |  | 25b. REGISTRAR'S SIGNATURE                            |  |
| George R. Snowden   |  | 246 N. Washington Street   |  | Rockville, Md. 20850   |  | OCT 22 1980  |  | [Signature]   |  |

BP

UNITED STATES

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 5 7 6 6<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Sadie Rapoport</b>   |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR <b>October 15, 1980</b>   |  |   |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>6 30 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>   |  | 7b CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESLADY</b>   |  | 12b KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>  |  |
| 13a STATE <b>md.</b> 13b COUNTY <b>Baltimore</b> 13c CITY OR TOWN <b>Baltimore</b>   |  |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS <b>#21215 6109 Park Heights Ave</b>  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>PHILLIP GLASS</b>  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATE HELLER</b>   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>212-09-3254A</b>   |  | 17 INFORMANT <b>MR. JERRY KATZEN</b> <b>303 NORTH ASPEN AVE., STERLING, VA 22170</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7425 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST (NON-TRAUMATIC)</b>  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN</b>   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>MELODYSPASTIC SYNDROME WITH PANCYTOPENIA</b>   |  |  |  | 2 YEARS   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>HYPERTENSION</b>  |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION <b>9 9</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)  |  | 21f LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 9, 19 80</b> , to <b>OCTOBER 15, 19 80</b> , that (I) (we) lost saw the deceased alive on <b>OCTOBER 14, 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b SIGNATURE <b>Mordo Suchowiewsky</b> DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 22c DATE SIGNED <b>10/15/80</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORDO SUCHOWIEWSKY</b>   |  |  |  | 22e ADDRESS <b>BELVEDERE # GREENSPRINGS</b>   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b DATE <b>OCT. 16, 1980</b>  |  | 23c NAME OF CEMETERY OR CREMATORY <b>WORKMEN CIRCLE</b>   |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>  |  |
| 24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; SONS, INC</b> <b>6010 REISTERSTOWN RD. BALTO. MD 21215</b>  |  |  |  | 25a DATE REC'D. BY REGISTRAR <b>OCT 22 1980</b>   |  | 25b REGISTRAR'S SIGNATURE <b>Rafaela McCreedy</b>   |  |

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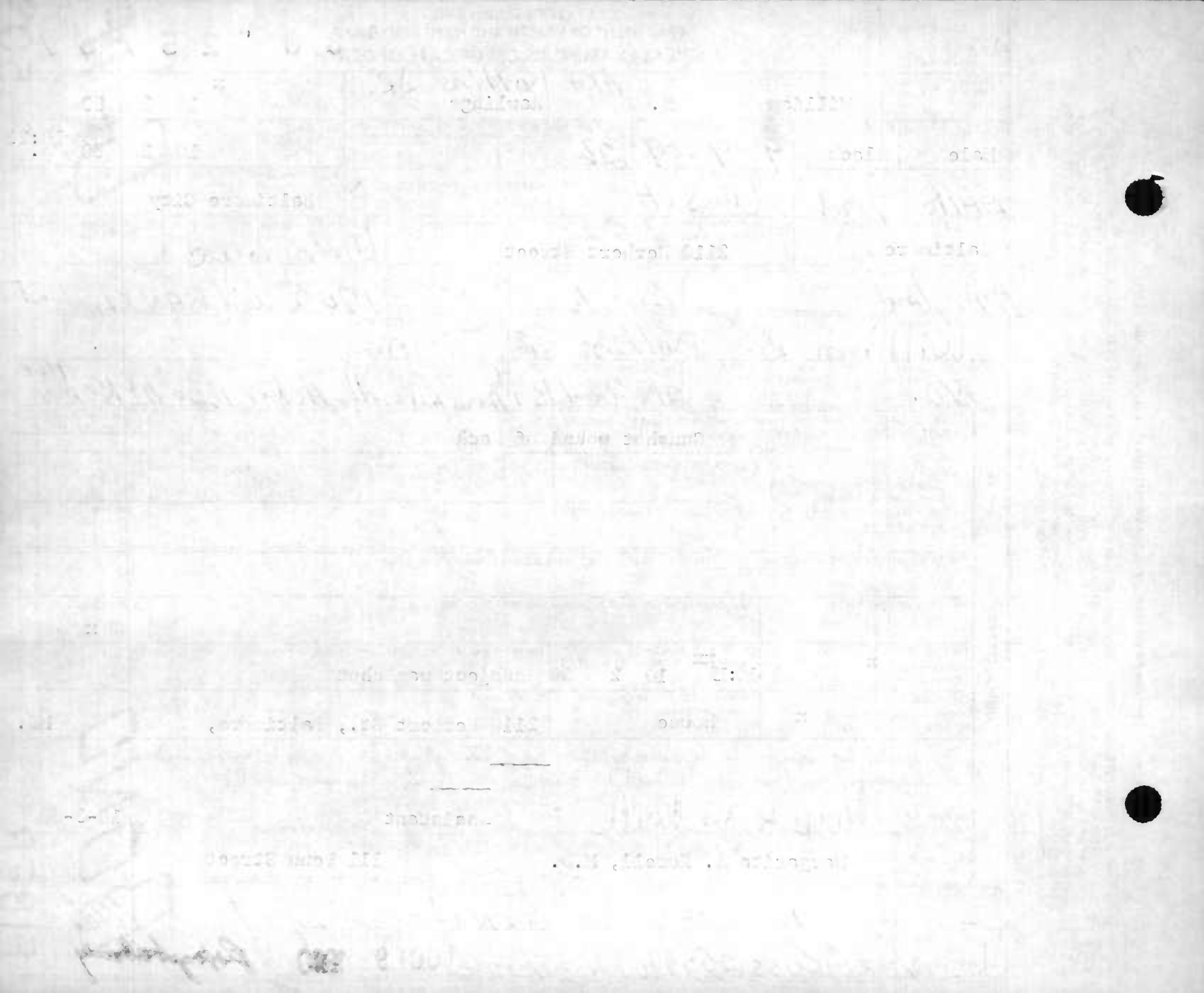
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |  |   |  |   |  |              |  |                                       |  |
|--|--|---|--|---|--|---|--|--|--|---|--|---|--|--------------|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>William  |  | MIDDLE<br>B.  |  | LAST<br>AKA Rollins JR.<br>Rawlings   |  | 2b. DATE KNOWN<br>OF DEATH<br>ESTIMATED  |  | <input checked="" type="checkbox"/> MONTH<br>10 |  | DAY<br>2  |  | YEAR<br>1980 |  | 2b. HOUR<br>M                         |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9-9-54  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>26 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                       |  | 2c. DATE<br>PRONOUNCED<br>DEAD                  |  | MONTH<br>10   |  | DAY<br>2     |  | YEAR<br>1980<br>24 HOUR<br>10:23 P.M. |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Baltimore, Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |   |  |   |  |              |  |                                       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2110 Herbert Street |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Unemployed |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |              |  |                                       |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1702 W. FRANKLIN ST                                     |  |   |  |   |  |              |  |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William B. Rollins SR  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary   |  | 16. SOCIAL SECURITY NO.<br>218-60-6159  |  |   |  |  |  |   |  |   |  |              |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO.   |  | 17. INFORMANT<br>Miss Brenda Acker 1628 W. Kean Ave   |  |   |  |   |  |  |  |   |  |   |  |              |  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gunshot wound of Back</u><br>9654<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |  |   |  |   |  |  |  |   |  |   |  |              |  |                                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |              |  |                                       |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR MIN. MONTH DAY YEAR<br>10:15 P.M. 10 2 19 80  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was shot   |  |   |  |  |  |   |  |   |  |              |  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house  |  | 21i. LOCATION<br>STREET<br>2110 Herbert St.,  |  | CITY OR TOWN<br>Baltimore,  |  | COUNTY   |  | STATE<br>Md.                                    |  |   |  |              |  |                                       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |  |   |  |   |  |   |  |  |  |   |  |   |  |              |  |                                       |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell  |  | TITLE (SPECIFY)<br>Assistant  |  | DATE SIGNED<br>10-3-80  |  |   |  |  |  |   |  |   |  |              |  |                                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | Margarita A. Korell, M.D.   |  | ADDRESS<br>111 Penn Street  |  |   |  |  |  |   |  |   |  |              |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)  |  | 23b. DATE<br>10-6-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN<br>Westport   |  | COUNTY   |  | STATE<br>Md.                                    |  |   |  |              |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | Joseph L. Russ  |  | ADDRESS<br>2222 W. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 9 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Rafaela Hardy                                    |  |   |  |   |  |              |  |                                       |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 3 FOR THE DIVISION OF VITAL RECORDS. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M 7/76

FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |  |   |   |   |   |  |  |
|--|---------|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |  | 2a. DATE KNOWN<br>OF DEATH  |   |   | 2b. HOUR  |  |  |
| FRANK NELSON RAYMOND, SR.  |         |  | MONTH DAY YEAR<br>10 8 1980                                       |   |   | M   |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   | IF UNDER 1 YR.  | IF UNDER 24 HRS.  | 7c. DATE<br>PRONOUNCED<br>DEAD                                      | 2d. HOUR                                   |  |
| male   | white   | MONTH DAY YEAR<br>10 10 1950   | 29 YRS.   | MONTHS DAYS   | HOURS MIN.  | MONTH DAY YEAR<br>10 8 1980   | 9:41 P M                                   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| NH   |         | USA  |   |   |   | Baltimore City MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |  |
| Baltimore  |         | South Balto. Gen. Hospital   |   | Truck driver  |   | Unknown   |  |  |
| 13a. STATE   |         |  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |  |  |
| AZ   |         |  | Unknown   | Phoenix   | YES <input type="checkbox"/> NO <input type="checkbox"/>                      | 88 East Weldon  |  |  |
| 14. FATHER'S NAME  |         |  | 15. MOTHER'S MAIDEN NAME  |   |   |   |  |  |
| FIRST MIDDLE LAST<br>Jerry Raymond   |         |  | FIRST MIDDLE LAST<br>Nylene Tough                                 |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |   |  |  |
| No   |         |  | -   |   | Mrs. Peggy Raymond<br>88 East Weldon St. Phoenix, Arizona                     |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |   |   |   |   |  |  |
| PART I DEATH WAS CAUSED BY:  |         |  |   |   |   |   |  |  |
| IMMEDIATE CAUSE (a) Cranio-cerebral injuries   |         |  |   |   |   |   |  |  |
| 8147 } DUE TO, OR AS A CONSEQUENCE OF  |         |  |   |   |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |   |   |   |   |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |   |   |   |   |  |  |
| (c)  |         |  |   |   |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |   | 20. AUTOPSY?  |  |  |
|  |         |  |   |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>9:30 P.M. 10-8-1980 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |  |  |
|  |         |  |   |   | Pedestrian struck by tractor-trailer.   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |         |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |  |
|  |         |  | road  |   | Potter St. - Harbor Tunnel Ramp Balto. Md.                                    |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |         |  |   |   |   |   |  |  |
| ACTUAL<br>SIGNATURE  |         |  | TITLE (SPECIFY)   |   |   | DATE<br>SIGNED  |  |  |
| Ann M. Dixon, M.D.   |         |  | Assistant   |   |   | 10-9-80   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  | ADDRESS   |   |   |   |  |  |
| Ann M. Dixon, M.D.   |         |  | 111 Penn St.  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |
| Burial   |         |  | 10-17-80  |   | Mountain Meadows  |   | Payson Gila Arizona                        |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         |  | 25a. DATE REC'D. BY REGISTRAR                                     |   |   | 25b. RE   |  |  |
| Loring Byers Funeral Directors, P.A.<br>8728 Liberty Rd., Randallstown, MD 21133   |         |  | OCT 14 1980   |   |   | R. Byers  |  |  |

0881 11 700

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 5 7 6 9

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Geneva Rector</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 4 80</b>   |  | 2b. HOUR<br><b>1:30 AM</b>   |   |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 19 94</b>                          |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ashville, N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                              |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>house-wife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  |  |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wesley Davis</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>? Green</b>   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>213 09 1773D</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Leroy Rector 10326 Vincent Rd. 21162</b>        |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of the pancreas, ca. of bladder, CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/80</b> , 19 <b>80</b> , to <b>10/4</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10/4/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>C. Krause MD</b>  |  | DEGREE  |  | 22c. DATE SIGNED<br><b>10/4/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. Krause</b>  |  | 22e. ADDRESS  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/7/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>                          |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Baltimore</b>  |  | COUNTY<br><b>Md</b>   |  | STATE  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Walter Dabrowski</b>  |  | ADDRESS<br><b>1005 Dundalk Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 8 1980</b>                             |   |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Fitzroy Hubbard</b>                           |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Admission, N.Y.

Baltimore

Married

Wesley

no

ED

Baltimore City Hospital

Baltimore

David

513 04 17730

X

Baltimore City Hospital

X

Y

very recent 10030 - 10030

Baltimore City

house - wife

1315 Cavendish Way

Green

513 04 17730

home

Green

513 04 17730

MD

Baltimore

10030 - 10030

10030 - 10030

Baltimore

10030 - 10030

10030 - 10030

10030 - 10030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   | MIDDLE   | LAST   | 2a. DATE OF DEATH   | MONTH                      | DAY   | YEAR             | 2b. HOUR                                     |
|--|--|---|--|--|---|----------------------------|---|------------------|--|
| OLIVER   |  |   |  | ANGUSTINE REDDING  | 10  | 27                         | 80  |                  | 10:35P.M.                                    |
| 3. SEX   | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |                            | IF UNDER 1 YEAR   |                  | IF UNDER 24 HRS                              |
| MALE   | WHITE  |   | 7. 11 19   |  | 61 YRS.   |                            | MONTHS DAYS   |                  | HOURS MIN.                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                            |   |                  |  |
| USA md.  | USA  |   |  |  | BALTIMORE CITY MD.  |                            |   |                  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                            | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                  |  |
| BALTIMORE  | SINAI HOSPITAL OF BALTIMORE  |   |  |  | ELECTRICIAN   |                            | JERUSALEM STEEL CORP.   |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  | 13b. COUNTY   |                            |   |                  |  |
| MD.  |  |   |  |  |   |                            |   |                  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |  |   |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)                        |                            |   |                  |  |
| ROBERT MORTON REDDING  |  |   |  |  | MARY E. WINCHESTER  |                            |   |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  |  | 16b. SOCIAL SECURITY NO.  |                            |   |                  |  |
| YES  |  |   |  |  | WWW IL 215-09-8068  |                            |   |                  |  |
| 17. INFORMANT  |  |   |  |  | ADDRESS   |                            |   |                  |  |
| DELORES J. REDDING   |  |   |  |  | AS 13E  |                            |   |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |   |                            |   |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |   |                            |   |                  |  |
| IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA OF LUNG   |  |   |  |  |   |                            |   |                  | 4 mos.                                       |
| 1629   |  |   |  |  |   |                            |   |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |   |                            |   |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  |  |   |                            |   |                  |  |
| (b)  |  |   |  |  |   |                            |   |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |   |                            |   |                  |  |
| (c)  |  |   |  |  |   |                            |   |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |   |                            |   |                  |  |
| GRAM NEGATIVE SEPSIS, PANCYTOPENIA   |  |   |  |  |   |                            |   |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY?   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                  |  |
|  |  |   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |                            |   |                  |  |
|  |  | HOUR A.M. MONTH DAY YEAR  |  |  |   |                            |   |                  |  |
|  |  | P.M. 19   |  |  |   |                            |   |                  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |   |                            |   |                  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |   |                            |   |                  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from SEPT 18 19 80, to OCT 27 19 80, that (1) (we) last saw the deceased alive on OCT 27 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. |  |   |  |  |   |                            |   |                  |  |
| 22b. SIGNATURE   |  |   |  |  | DEGREE  |                            |   | 22c. DATE SIGNED |  |
| Mark Himmelher   |  |   |  |  | MD  |                            |   | 10/27/80         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |  | 22e. ADDRESS  |                            |   |                  |  |
| MARK HIMMELHER   |  |   |  |  | SINAI HOSPITAL OF BALTIMORE   |                            |   |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION CITY OR TOWN |   | COUNTY           | STATE  |
| CREMATION  |  | 10/29/80  |  | GREEN MOUNT  |   | BALTO. MD.                 |   |                  |  |
| 24. FUNERAL DIRECTOR   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR                                       |                            | 25b. REGISTRAR'S SIGNATURE  |                  |  |
| WALTER BROOKS BRADLEY, INC. BALTO  |  |   |  |  | OCT 31 1980   |                            | Lester R. R.  |                  |  |

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   | 8 0 2 5 7 7 1<br>REG. NO.  |   |   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George L. Reid</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 25, 1980</b>   |   |   |   | 2b. HOUR<br><b>12:16A<sub>M</sub></b>  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 17 09</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alexandria, Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner-Oper. George L. Reid Co.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. CITY OR TOWN<br><b>Larchmont</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>2618 Poplar Drive, 21207</b>                             |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Harrison Reid</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Ann Hall</b>   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>212-03-1674</b>   |   | 17. INFORMANT<br><b>Mrs. Audrey K. Reid, 2618 Poplar Drive, Woodlawn, Maryland 21207</b>        |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction - Probable</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Coronary Vascular Disease</b> Years<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chronic Renal Insufficiency, Diabetes Mellitus, Seizures</b>  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 12, 1980</b> to <b>October 25, 1980</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>October 25, 1980</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Eric Fisher</b>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>10/25/80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eric Fisher, M.D.</b>  |  |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>   |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>10/27/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Mausoleum</b>                                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Baltimore, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Loring Byers Funeral Directors, P.A.</b><br><b>8728 Liberty Road, Randallstown, Md. 21133</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1980</b>   |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO. 8 0 2 5 7 7 2 |  |
|---|--|---|--|---|--|---|--|---|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Glenn F. Reinicker</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 12, 1980</b>                                     |  | 2b. HOUR<br><b>5:00am</b>   |  |                        |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 10, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>   |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                                |  |   |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fuel Dealer</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Enterprise Fuel Co.</b>   |  |                        |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6903 Lachlan Circle # E</b>   |  |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick G. Reinicker</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary L. Erdman</b>  |  |   |  |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213 28 0630</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Elizabeth G. Reinicker Same</b>  |  |   |  |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia and Resolving Pulmonary infarcts</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Subacute Pelvic Peritonitis and Diverticulitis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Active Prepyloric Peptic Ulcer</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |   |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>1. Prostatic Carcinoma 2. Arteriosclerotic Cardiovascular Disease</b>   |  |   |  |   |  |   |  |   |  |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |                        |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>July 6, 1980</b> to <b>October 12, 1980</b> , that (X) (we) lost<br>saw the deceased alive on <b>October 12, 1980</b> , and that (X) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (X) (we) (did) (not) view the body after death.   |  |   |  |   |  |   |  |   |  |                        |  |
| 22b. SIGNATURE<br><b>Wiley A. Patterson M.D.</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>10/12/80</b>   |  |   |  |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wiley A. Patterson, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>c/o 827 Linden Ave. Balto. MD 21201</b>  |  |   |  |   |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/15/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b>                            |  |   |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co.<br/>4905 York Road Balto., Md. 21212</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Petrysky</b>   |  |   |  |                        |  |



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3

1 - STATE REGISTRAR

8025773

REG. NO.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
INEE (Eve) Reinsfelder

2a. DATE OF DEATH MONTH DAY YEAR  
10/10/80

2b. HOUR  
10 43 A.M.

3. SEX  
Female

4. RACE  
White

5. DATE OF BIRTH MONTH DAY YEAR  
06 15 17

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS  
63

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
North Carolina

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
S. Baltimore City MD.

10. CITY OR TOWN OF DEATH  
S. Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
S. Balt. General Hosp

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
Nursing Home Patient

12b. KIND OF BUSINESS OR INDUSTRY  
Housewife

13a. STATE  
MD

13b. COUNTY  
Baltimore

13c. CITY OR TOWN  
Baltimore

13d. INSIDE CITY LIMITS?  
YES ☒ NO ☐

13e. STREET ADDRESS  
1605 HARVEY ST.

14. FATHER'S NAME FIRST MIDDLE LAST  
unknown Brown

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
unknown Bessie --- Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  
no

16b. SOCIAL SECURITY NO.  
249-18-7690

17. INFORMANT ADDRESS  
MICHAEL KENT 3001 S. HARVEY ST

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic ENCEPHALOPATHY  
5738  
DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic INSUFFICIENCY  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
unknown

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION  
none

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
none

20a. AUTOPSY?  
YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
none

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  
none

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐  
none

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  
none

21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
none

22a. I certify that (I) (this hospital) attended the deceased from 10/1 19 80, to 10/10 19 80, that (I) (we) last saw the deceased alive on 10/10 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
Michael Kent, MD

DEGREE  
MD

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED  
10/10/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)  
MICHAEL KENT, MD

22e. ADDRESS  
3001 S. HARVEY ST S. Balt. MD 21230

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  
Burial

23b. DATE  
Oct. 14, 1980

23c. NAME OF CEMETERY OR CREMATORY  
Cedar Hill Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE  
Baltimore, Maryland

24. FUNERAL DIRECTOR NAME ADDRESS  
McAlly Funeral Home, 130 E. Fort Ave. Balto. Md.

25a. DATE REC'D. BY REGISTRAR  
OCT 14 1980

25b. REGISTRAR'S SIGNATURE  
[Signature]

DHM-16 25M  
(VRA 15, 4) 1/79



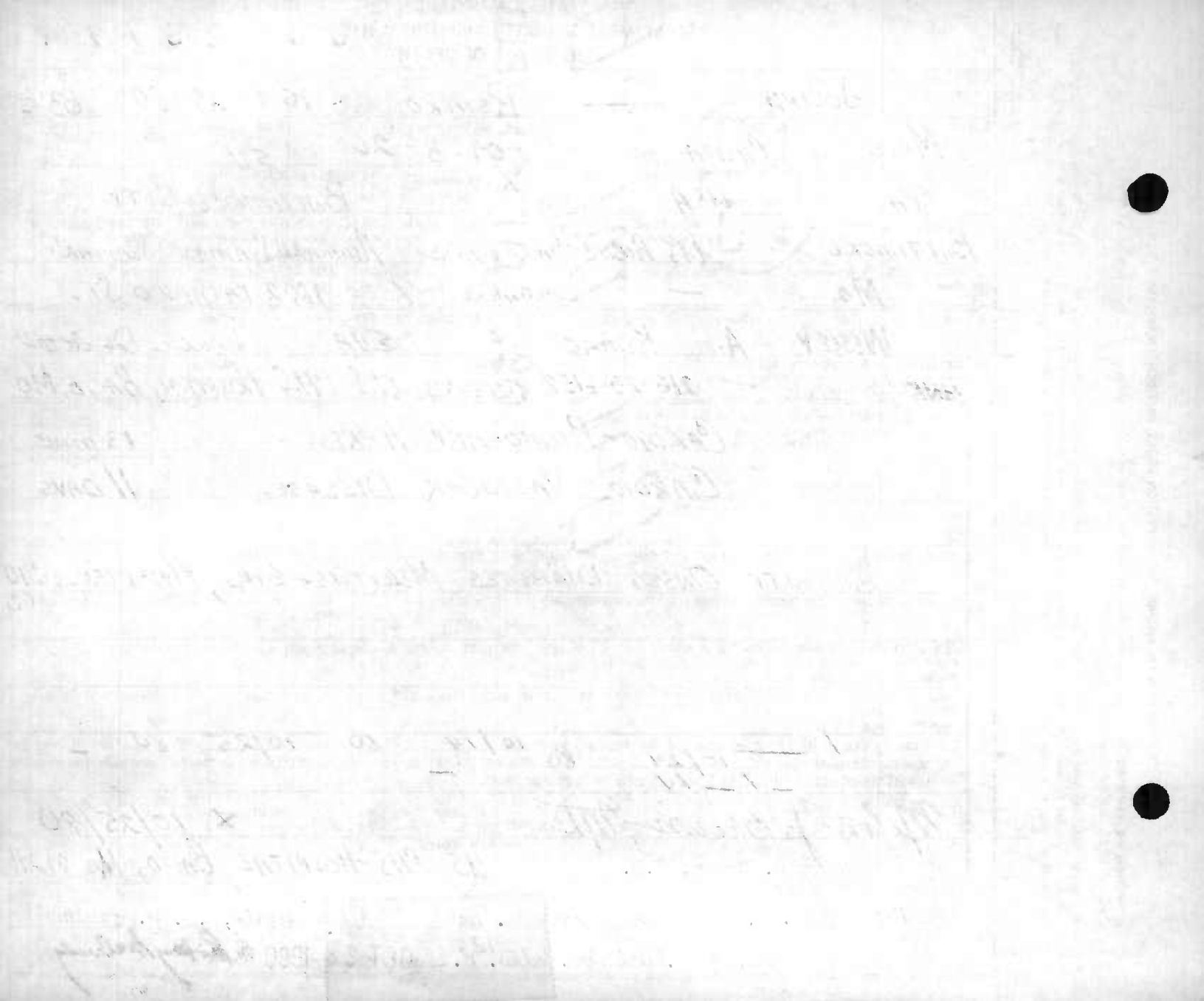
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25774

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>JOSEPH</b> First Middle Last <b>REMKO</b>  |  | 2a. DATE OF DEATH<br><b>10</b> Month <b>25</b> Day <b>80</b> Year   |  | 2b. HOUR<br><b>03:12</b> M  |   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br><b>09-3-'26</b>   |   |
| 6. AGE (In years lost birthday)<br><b>54</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  | IF UNDER 24 HRS<br>HOURS MIN  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |  | Md.   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>U.S. PUBLIC HEALTH SERVICE</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>AMERICAN SEAMAN</b>   |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SEAMAN</b>  |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>       |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   |
| 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                   |  | 13e. STREET AND NUMBER<br><b>1802 PATAPSCO ST.</b>  |   |
| 14. FATHER'S NAME First Middle Last<br><b>WESLEY A. REMKO</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>EVA DIACA DE BORO</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>YES W.W.II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-20-6152</b>  |  | 17. INFORMANT<br><b>RECORDS U.S. PHS HOSPITAL, BALTO, MD.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIO-VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>4292</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>13 MINS.</b><br><b>11 DAYS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>MATURITY ONSET DIABETES MELLITUS-6 YRS; HYPERTENSION-10 YRS</b>   |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  | YRS   |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/14</b> , 19 <b>80</b> , to <b>10/25</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/24</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Melva J. Brown, M.D.</b> DEGREE<br>22d. PHYSICIAN'S NAME (Type)<br><b>Melva J. Brown, M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>10/25/80</b><br>22e. ADDRESS<br><b>U.S. PHS HOSPITAL, BALTO, MD 21211</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Oct. 29, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>   |   |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Glen Burnie, A.A. Co. Maryland</b>  |  | 24. FUNERAL DIRECTOR ADDRESS<br><b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</b>                    |  |   |   |
| 25a. REC'D BY REGISTRAR<br><b>OCT 28 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McBrine</b>   |  |   |   |



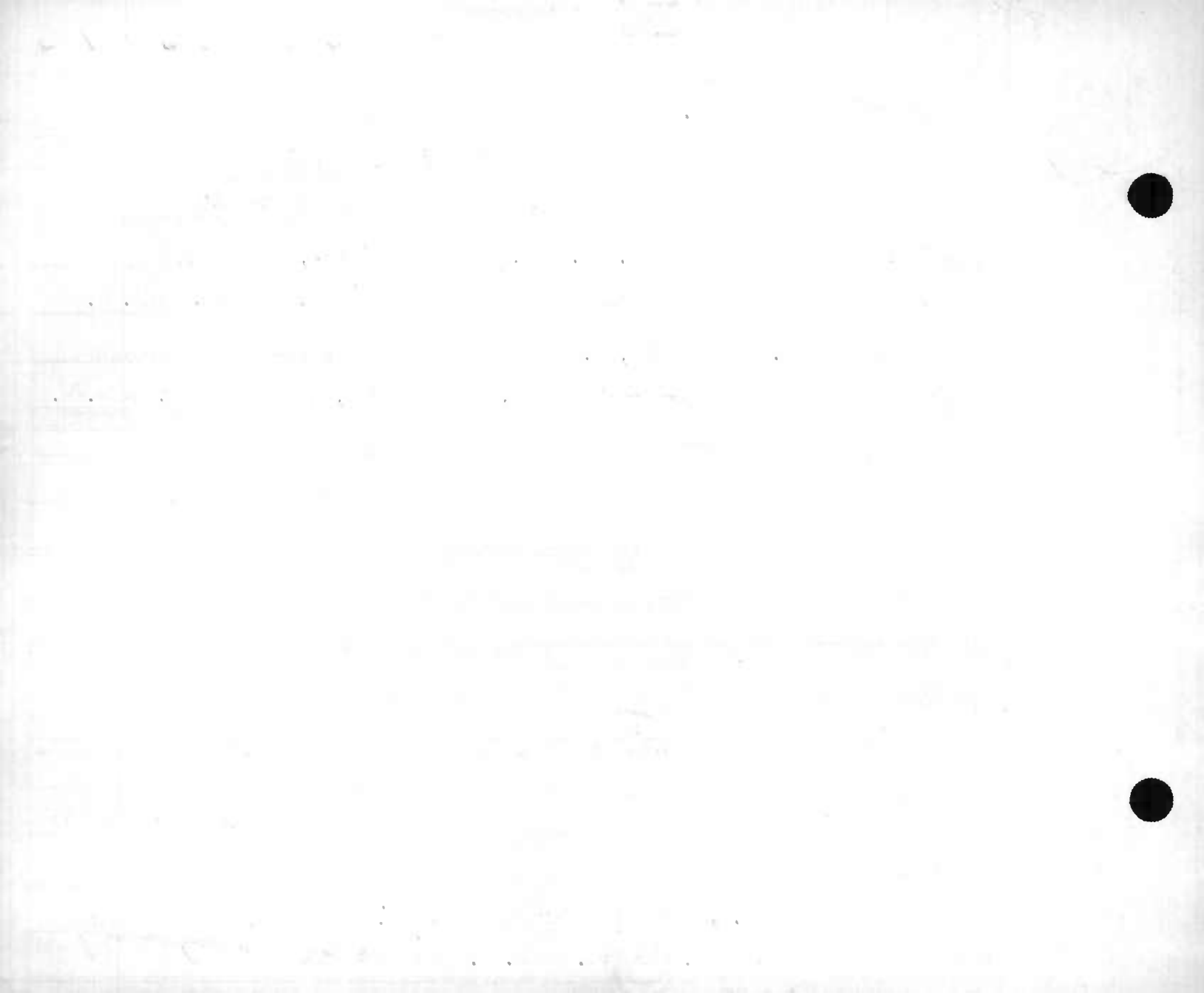
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 8 0 2 5 7 7 5<br>REG. NO.   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>KATHERINE V. RETOWSKY   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCT 8 80                                       |  | 2b. HOUR<br>6:00 PM   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 - 3 - 07   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br>73  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                         |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Balto. Gen. Hosp. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner, Restaurant |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>644 E. Fort Ave. Balto. Md.                                 |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William F. Gliss, Sr.  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Pearl Taylor  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO<br>212-16-6171   |  | 17. INFORMANT ADDRESS<br>Mrs. Alberta Poist, 1312 Bonsal St. Balto. Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular accident.<br>1533<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma of sigmoid, resected recently.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)         |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/26/80 to 10/8/80, that (I) (we) last saw the deceased alive on 10/8/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Stavrou   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>10/8/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>NICOS STAVROU  |  |   |  | 22e. ADDRESS<br>SRGH  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>Oct. 9, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process Inc.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                      |  |   |  |
| 24. FUNERAL DIRECTOR<br>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |  | 25b. SIGNATURE   |  |   |  |



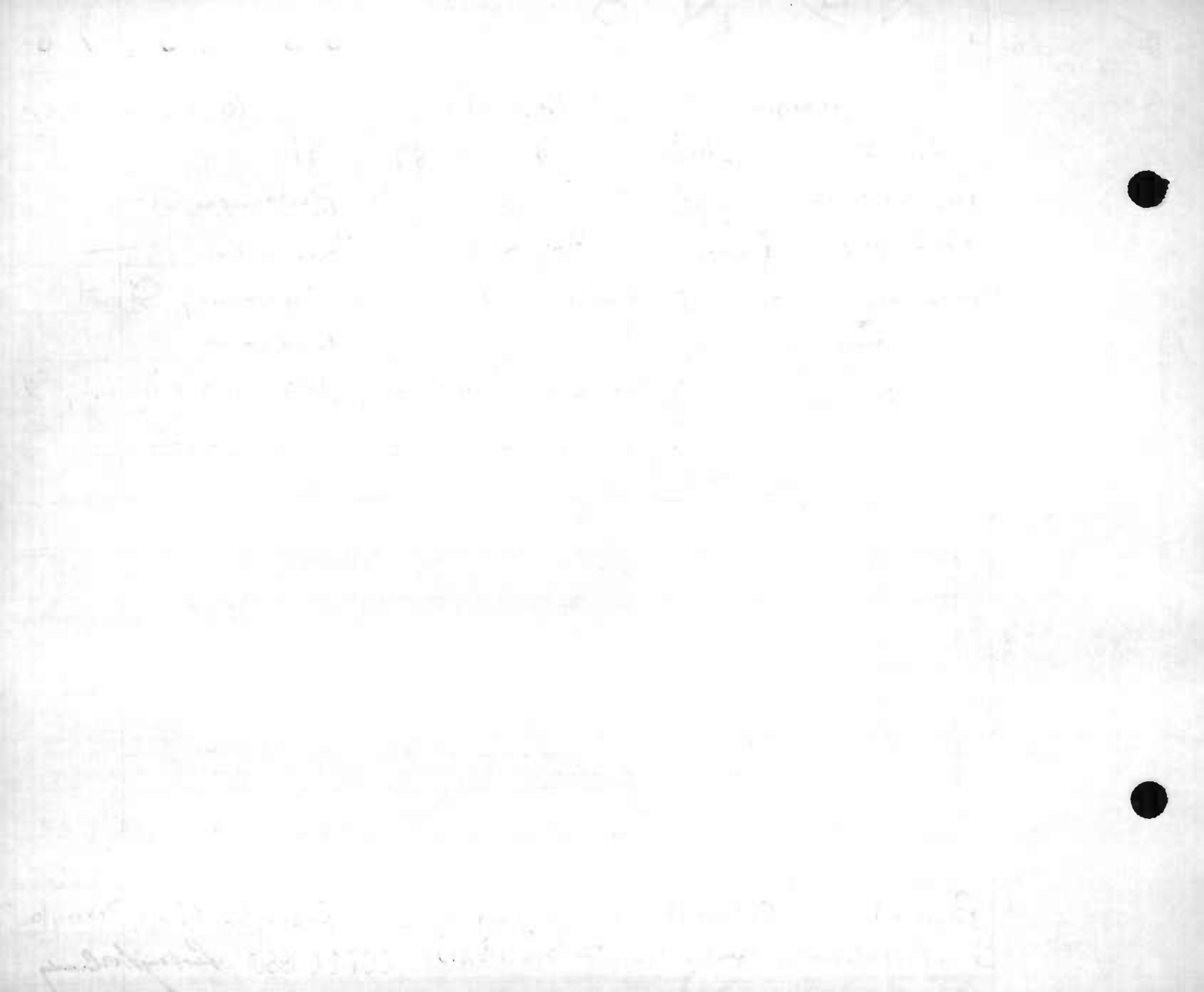
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  | 7 0 2 5 7 7 6  |  |  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| Armenia B. Reynolds  |  |  |  |  |  |  |  | 10 03 80  |  | 12:15 PM                                     |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN                    |  |
| Female   |  | white  |  | 2 - 20 - 89  |  | 91   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Pennsylvania   |  | USA  |  |  |  | Baltimore City MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore  |  | Baltimore City Hospitals   |  |  |  | Homemaker  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland   |  |  |  | Baltimore  |  | YES  |  | 927 N. Jannay Street  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |  |  |
| George Carroll   |  | unknown  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  |  |  |   |  |  |  |
| No   |  | 215661608  |  | Philip K. Reynolds   |  | 927 N. Jannay St.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4275  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/27, 1980, to 10/3/80, 1980, that (I) (we) last saw the deceased alive on 10/3, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| Robert T. Schreiber  |  | MD   |  |  |  |  |  | 10/3/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |  |
| Robert T. Schreiber  |  | Balt. City Hosp., Eastern Ave., Balt. Md.  |  |  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial   |  | Oct. 6, 1980   |  | West Nottingham Presby. Cem.   |  | Rising Sun, Cecil, Maryland  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR (NAME)  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |
| Couch Parkside Funeral Home Inc. 4210 Belair ROAD  |  | OCT 10 1980  |  |  |  | History/Kalinsky   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |  |  |   |  |  |   | 8 0 2 5 7 7 7   |          |   |  |   |  |
|---|--|--|---|--|--|---|--|--|---|---|----------|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |   |  |  |   |  |  |   | REG. NO.  |          |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH   |  |  | MONTH DAY YEAR  |   | 2b. HOUR |   |  |   |  |
| ESTHER R. RHEB  |  |  |   |  |  | 10-19-80  |  |  | 4:35P   |   | M        |   |  |   |  |
| 3 SEX   |  |  | 4 RACE  |  |  | 5. DATE OF BIRTH  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |   |          | IF UNDER 1 YEAR   |  |   |  |
| FEMALE  |  |  | WHITE   |  |  | MONTH DAY YEAR  |  |  | 86 YRS.   |   |          | IF UNDER 24 HRS   |  |   |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |          |   |  |   |  |
| MARYLAND  |  |  | U.S.A.  |  |  |   |  |  | BALTIMORE CITY  |   |          | MD  |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |          |   |  |   |  |
| BALTIMORE   |  |  | ST. AGNES HOSPITAL  |  |  | OWNER   |  |  | CANDY CO.   |   |          |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |   |          | 13e. STREET ADDRESS   |  |   |  |
| MARYLAND  |  |  | ---   |  |  | BALTIMORE   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |          | 3352 WILKENS AVENUE, 21229  |  |   |  |
| 14 FATHER'S NAME  |  |  | 15 MOTHER'S MAIDEN NAME   |  |  |   |  |  |   |   |          |   |  |   |  |
| FIRST MIDDLE LAST   |  |  | FIRST MIDDLE LAST   |  |  |   |  |  |   |   |          |   |  |   |  |
| JOHN BRAUN  |  |  | CARRIE BUTCHER  |  |  |   |  |  |   |   |          |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT   |  |  | ADDRESS   |   |          |   |  |   |  |
| NO  |  |  | 212-44-1299   |  |  | ALBERT L. RHEB  |  |  | 3352 WILKENS AVENUE, 21229  |   |          |   |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u><br>485-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Multiple myeloma</u> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH               |          |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |   |  |  |   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED              |          | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |   |  |  |   |  |  |   |   |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |  |  |   |   |          |   |  |   |  |
|   |  |  | P.M. 19   |  |  |   |  |  |   |   |          |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |          |   |  |   |  |
|   |  |  |   |  |  |   |  |  |   |   |          |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10.12.1980</u> to <u>10.19.1980</u> , that (I) (we) last saw the deceased alive on <u>10.19.1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |   | 22b. SIGNATURE<br><u>V. Narayan</u><br>DEGREE                 |          | 22c. DATE SIGNED<br><u>10/19/80</u>                                 |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>V. Narayan</u>  |  |  |   |  |  |   |  |  |   | 22e. ADDRESS<br><u>ST. AGNES HOSPITAL 900 S. CATON AVENUE</u> |          |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |   |          |   |  |   |  |
| BURIAL  |  |  | 10-22-80  |  |  | LOUDON PARK   |  |  | BALTIMORE CITY MARYLAND   |   |          |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | ADDRESS   |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |   |          |   |  |   |  |
| HUBBARD FUNERAL HOME, INC.  |  |  | 4107 WILKENS AVE.   |  |  | 21229   |  |  | OCT 21 1980   |   |          | <u>[Signature]</u>  |  |   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 7 8

REG. NO.

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Adam Theodore Rhein</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 15, 1980</b> |   |  | 2b. HOUR<br><b>M</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 29, 1897</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86-82</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1526 Ralworth Road</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Telegrapher - Western Union</b>                     |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1526 Ralworth Road</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gabriel John Rhein</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Rebbert</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-0255</b>   |   | 17. INFORMANT <b>Wife:</b> ADDRESS <b>21218 Marie M. Rhein 1526 Ralworth Rd. Balto. Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary Insufficiency</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of the Prostate</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b><br><b>2 yrs.</b> |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 7, 1979</b> to <b>Oct 15, 1980</b> , that (I) (we) last saw the deceased alive on <b>Sept 19, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>George J. Richards M.D.</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |   | 22c. DATE SIGNED<br><b>10/10/80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George J. Richards M. D.</b>  |  |  |   | 22e. ADDRESS<br><b>G.B.M.C. Hospital, Towson, Maryland</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/18/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Funeral Home, Inc. Balto., Md.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 16 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. [Signature]</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11 2 0 0

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 80125779  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Cordelia W Rhinehart</b>  |  |  |  | 2. DATE OF DEATH MONTH DAY YEAR<br><b>October 2, 1980</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>October 27, 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>79</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Hamilton Nursing Center</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Home Maker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles W Rhinehart</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Rose Allen</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-54-1368</b>   |  |
| 17. INFORMANT ADDRESS<br><b>Mrs Mary Jane Laird</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1. Disseminated Lupus Erythematosus</b><br><b>7100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>2. ASHWD - CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                               |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Oct 1</b> , 19 <b>80</b> to <b>Oct 2</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Oct 1</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Donald W. Mintzer M.D.</b>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><b>10/3/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald W Mintzer M.D.</b>  |  | 22e. ADDRESS<br><b>3009 Evergreen Ave Baltimore, Md</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/4/80</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore</b>   |  | 23d. LOCATION<br><b>Baltimore, Maryland</b>  |  | 24. FUNERAL DIRECTOR NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 3 1980</b>   |  |



SECRET NOT TO BE RELEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |                           |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                      |  |  |  | 80 25780   |  |  |  |
|---|--|---------------------------|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                           |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR   |  |  |  |
| Cornelia G. Rhodes  |  |                           |  | 10/20/80  |  |  |  | 5 P. M.  |  |  |  |
| 3. SEX  |  | 4. RACE                   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR   |  | 8. IF UNDER 24 HRS.  |  |
| Female  |  | Black                     |  | 5 19 92   |  | 88   |  | MONTHS   |  | DAYS   |  |
| 9. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 10. CITY OR TOWN OF DEATH |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| MD  |  | Baltimore                 |  | Greater Penn N/H  |  | Baltimore City   |  |  |  | MD.  |  |
| 13a. STATE  |  | 13b. COUNTY               |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |  |
| MD  |  |                           |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | Greater Penn N/H   |  |  |  |
| 14. FATHER'S NAME   |  |                           |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |
| Alexis  |  |                           |  | Lillian   |  |  |  | Williams   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |                           |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |
| No  |  |                           |  | N/A   |  | Barbara Rhodes   |  | 3227 Ingleside Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                           |  |   |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |                           |  |   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u>   |  |                           |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                           |  |   |  |  |  |  |  |  |  |
| (b) _____   |  |                           |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |                           |  |   |  |  |  |  |  |  |  |
| (c) _____   |  |                           |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                           |  |   |  |  |  |  |  |  |  |
| <u>Carcinoma @ Breast</u>   |  |                           |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |                           |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                           |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |                           |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 79</u> to <u>20 Oct 19 80</u> , that (I) (we) lost<br>saw the deceased alive on <u>10-15-19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |                           |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |                           |  | DEGREE  |  |  |  | ATTENDING <input checked="" type="checkbox"/> PHYSICIAN MEDICAL <input type="checkbox"/> DIRECTOR STAFF <input type="checkbox"/> PHYSICIAN |  | 22c. DATE SIGNED   |  |
|   |  |                           |  |   |  |  |  |  |  | 10-21-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |                           |  | 22e. ADDRESS  |  |  |  |  |  |  |  |
| DARSHAN S. SALUJA MD  |  |                           |  | 1600 MT Royal Ave, Balto. 21217   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |                           |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| Burial  |  |                           |  | 10/24/80  |  | Arbutus Mem. Pk.   |  | Baltimore CO. MD   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |                           |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.   |  |                           |  | OCT 22 1980   |  |  |  | [Signature]  |  |  |  |

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Aboriginal to the land

Conservation (C) Forest

10-15-80 Jan 20 80

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10-15-80

1000 MT high forest, 10000

DATE JAN 2 1980

~~10-15-80~~



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 8 1

REG. NO.

|  |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>CLARENCE RICE  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 13 1980 |   |   | 2b. HOUR<br>8:45 AM   |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 20 1910   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>70  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Drake, S.C.                                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Steel                       |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |   |   |  |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Balto.   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2625 Robb Street      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Rice                                       |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Huggins |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no                   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212 10 1353   |  | 17. INFORMANT ADDRESS<br>Gerzldine Wilson 2625 Robb St.   |   |   |  |  |  |

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>probable sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>leg gangrene</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>popliteal artery insufficiency</u>  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>massive CVA with hemiparesis, aphasia, incontinence of stool &amp; urine</u>  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>July 30, 1980   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>inability to eat - feeding gastrostomy |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                     |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>24 August</u> 19 <u>80</u> , to <u>13 October</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11 October</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Julie A. Goepel.  |  |  |  | DEGREE<br>MD  |  |  |  | 22c. DATE SIGNED<br>13 October 80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JULIE A. GOEPEL, M.D.  |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL                                       |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/16/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown Md.                       |  | 23e. DATE RECD BY REGISTRAR<br>OCT 15 1980  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Jas. A. Morton & Sons 1701 <sup>ESS</sup> Laurens St.  |  |  |  |   |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 80 25 / 82  |  |
|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 3. SEX  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>John W. W Ford (Ridenbaugh)  |  | M Male  |  | MONTH DAY YEAR<br>10 11 80  |  |
| 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| W White   |  | MONTH DAY YEAR<br>4 21 88   |  | 72-72 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| MD.   |  | U.S.  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALT CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| BALTIMORE   |  | UNIVERSITY HOSP.  |  | Retired   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| MD.   |  | Allegany  |  | OLD TOWN  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 13d. INSIDE CITY LIMITS?  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| Walter Ridenbaugh   |  | Clara Miller  |  | 13e. STREET ADDRESS   |  |
|   |  |   |  | Route 1 Box 367   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  |
| UNKNOWN No  |  | No  |  | 214-07-6590   |  |
|   |  |   |  | INPATIENT REGISTRATION RECORD (wife)  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gastric intestinal hemorrhage</u><br>5714 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Esophageal varices</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic active hepatitis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>13 hours |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  |
|   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) this hospital attended the deceased from <u>9/27</u> 19 <u>80</u> , to <u>10/11</u> 19 <u>80</u> , that (1) (we) lost<br>saw the deceased alive on <u>10/11</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I/we) did (did not) view the body after death.   |  | 22b. SIGNATURE<br><u>Myhaus MD</u>  |  | 22c. DATE SIGNED<br>10/11/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 22f. DATE RECD. BY REGISTRAR  |  |
| HARRIS  |  | UNIV. HOSP.   |  | OCT 15 1980   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| Burial  |  | 10-15-1980  |  | Davis Memorial Cem.   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  |
| James F. Scarpelli, Cumberland, Md.   |  |   |  | OCT 15 1980   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                         |  |   |  |   |   |  |   |  |
|--|-------------------------|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Michael E. Riley</b>   |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>10 7 1980</b> |  |   | 2b. HOUR<br><b>M</b>  |  |   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9/06/1961</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>19</b> YRS.                                      | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | 7c. DATE PRONOUNCED DEAD<br><b>10 7 1980</b>  | 7d. HOUR<br><b>1:19A</b><br><b>M</b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD</b>                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Security Guard</b>                            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Security</b> |   |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>----</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>142 N. Haven Street</b>                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Plunkett</b>  |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carolyn S. Riley</b>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>214-90-8590</b>   |   | 17. INFORMANT ADDRESS<br><b>900 S. Kenwood Avenue<br/>Mrs. Carolyn S. Keener-Balto., Md.</b>   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br><b>8147</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>21224.</b>                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br><b>7:35 P.M. 10 6 1980</b>                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>pedestrian struck by auto</b> |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7910 Pulaski Hwy. near Rosedale, Balto.Co., MD</b>        |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |                         |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>  |  |   |   |  | DATE SIGNED<br><b>10/7/80</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                         |  | ADDRESS<br><b>111 penn St. Balto., MD.</b>  |  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>10/10/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park- Baltimore, Maryland</b>                          |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>John A. Moran, Inc.</b>  |                         |  | ADDRESS<br><b>3000 E. Baltimore St. Baltimore Md 21224</b>                                |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Robert McCreedy</i>                                |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 8 4  
REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VIRGINIA E. RIVAS</b>                            |  |   | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>26</b> YEAR <b>80</b> |   |  | 2b. HOUR<br><b>10<sup>10</sup> A.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>08</b> YEAR <b>29</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NURSE</b>                |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing</b>                                     |  |   |   |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>AQUILA</b> MIDDLE <b>Walter</b> LAST <b>Walter</b>        |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Arian</b> MIDDLE <b>Curtain</b> LAST <b>Curtain</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT<br>ADDRESS<br><b>Patricia Rivas 834 Cooks Lane</b>  |  |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metabolic Acidosis / Hypovolemia</b><br><b>5339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Gastric outlet obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Peptic ulcer disease</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>5 days</b><br><b>many years.</b> |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert Artwohl MD</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT ARTWOHL</b>  |  |  |  | 22e. ADDRESS<br><b>University Hospital</b>   |  |   |  |

|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/30/80</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Frederick Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>1630 Edmondson Ave. Catonsville, Md</b><br><b>Witzke Funeral Home of Catonsville, P.A. 21228</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1980</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Rivas</b>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



2025 COTTON FIBER

2025 COTTON FIBER



*[Faint, illegible handwritten text covering the majority of the page, possibly bleed-through from the reverse side.]*

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| FOR STATE REGISTRAR   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 5 7 8 5   |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|
| 1 -   |  |   |  | CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR  |  |  |  |
| HELEN C ROBERTS   |  |   |  | OCTOBER 14, 1980   |  |  |  | 6:05R   |  |  |  |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  |
| Female  |  | B   |  | 12 25 15   |  | 65   |  | MONTHS  |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Washington D.C.   |  | USA   |  |  |  | BALTIMORE CITY MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore   |  | THE JOHNS HOPKINS HOSPITAL                              |  |  |  |  |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13d. INSIDE CITY LIMITS?   |  |  |  | 13e. STREET ADDRESS   |  |  |  |
| 13a. STATE MD   |  |   |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN Baltimore   |  |  |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |
| John W. Shields   |  |   |  | Mary Anne James  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO  |  |   |  | 16b. SOCIAL SECURITY NO. 214-18-3729   |  | 17. INFORMANT Karroll Parker 304 Sheffield Ct. Joppa Md.                       |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |  |  |  |   |  | 18 months  |  |
| IMMEDIATE CAUSE (a) Small cell carcinoma of lung - multiple metastatic lesions  |  |   |  |  |  |  |  |   |  |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b)   |  |   |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
|   |  |   |  | P.M. 19  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY STATE   |  |
|   |  |   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from October 3, 19 80, to October 14, 19 80, that (we) last saw the deceased alive on October 14, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE   |  |  |  | 22c. DATE SIGNED  |  |  |  |
| Robert J. Mandel  |  |   |  | M.D.   |  |  |  | 10/14/80  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |
| Robert J. Mandel  |  |   |  | 601 N. Broadway Balt md 21205  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  |  |  |
| Burial  |  |   |  | 10/17/80   |  | Baltimore Cemetery   |  | Baltimore MD  |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |   |  | 25a. DATE REC'D BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Wm. C. March Funeral Home Inc. 1101 E. North Ave  |  |   |  | OCT 15 1980  |  |  |  | [Signature]   |  |  |  |

20:1 GPT

SECRET NOTECOR 201



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |                         |  |  |  |  |  |   |  |   |  |   |  |
|---|--|-------------------------|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Charles Adams Roeder</b>   |  |                         |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 10 5 19 80    |  |   |  | 2b. HOUR<br>M   |  |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 19 10</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>70 YRS.</b>                                   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>10 5 19 80</b> |  | 2d. HOUR<br><b>9:59A</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5715 Falls Road</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Broadcaster</b>   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Radio</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  |                         |  | 13b. COUNTY<br><b>Balto.</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS<br><b>5715 Falls Road</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adam Roeder</b>  |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Edith Holzshu</b>                  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |                         |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-07-9551</b>   |  |   |  |   |  | 17. INFORMANT ADDRESS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: <b>Gun shot wound of head</b><br><b>9554</b> IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                         |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION  |  |                         |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9:55 P.M. 10/ 5 19 80</b>        |  |   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>self inflicted gun shot wound</b> |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>front steps/home</b> |  |   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5715 Falls Road, Baltimore City MD</b>                        |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .  |  |                         |  |  |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b> M.D.  |  |                         |  |  |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER                                   |  |   |  |   |  | DATE SIGNED <b>10/6/80</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  |                         |  |  |  | ADDRESS<br><b>111 Penn Street, Baltimore, MD.</b>                                      |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  |                         |  | 23b. DATE<br><b>10/6/80</b>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Anatomy Board Balto., Md.</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>                                    |  |   |  |   |  | 25b. SIGNATURE OF REGISTRAR<br><i>[Signature]</i>   |  |

0.015

Oil

1230-70-212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 5 7 8 7<br>REG. NO.   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JUSTIN P ROMBERGER  |  |   |  | 2b. HOUR<br>6:40A M   |  |   |  |
| 3 SEX<br>MALE   |  | 4 RACE<br>CAU   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 26 80   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN<br>4   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO CITY MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTO   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIV OF MD HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN<br>PA Dauphin HARRISBURG  |  |   |  | 13e. STREET ADDRESS<br>RD 1 Box 422 HALIFAX RD  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MARLIN ROMBERGER   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>PATRICIA LESTER   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |   |  |
| 16b. SOCIAL SECURITY NO   |  | 17. INFORMANT ADDRESS<br>MARLIN Romberger   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST<br>7471<br>DUE TO, OR AS A CONSEQUENCE OF (b) UNCONTROLLABLE HEMORRHAGE<br>DUE TO, OR AS A CONSEQUENCE OF (c) REPAIR OF COARCTATION, PULMONARY BANDING<br>4 days    |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>10/31/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CONGENITAL HEART DISEASE  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/30 1980, to 10/31 1980, that (I) (we) last saw the deceased alive on 10/30 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Bhupinder Singh   |  |   |  | DEGREE<br>MBBS ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED<br>10/31   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BHUPINDER SINGH  |  |   |  | 22e. ADDRESS<br>UMH BALTO MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>11-3-1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FRIEVEL   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>JACKSON Twp Dauphin Pa   |  |
| 24. FUNERAL DIRECTOR NAME<br>Walter N. Hooper   |  |   |  | ADDRESS<br>1185 Mt Millersburg Pa   |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 7 1980  |  |
|   |  |   |  | 25. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |         |   |        |   |     |   |              |
|--|---------|---|--------|---|-----|---|--------------|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE OF DEATH   |        | MONTH   | DAY | YEAR  | 2b. HOUR     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   | MIDDLE | LAST  | 10  | 12  | 80 3:55 P.M. |
| CLARENCE T ROSS  |         |   |        |   |     |   |              |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS LAST BIRTHDAY)   |     | 7. UNDER 1 YEAR   |              |
| Male   | Black   | MONTH 1 DAY 11 YEAR 23  |        | 57  |     | IF UNDER 24 HRS   |              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |     | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |              |
| Maryland   |         | U. S. A.  |        |   |     | Baltimore City MD.  |              |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |     | 12b. KIND OF BUSINESS OR INDUSTRY   |              |
| Baltimore  |         | VAMC, Baltimore, Maryland 21218   |        | Machenist   |     |   |              |
| 13a. STATE   |         | 13b. COUNTY   |        | 13c. CITY OR TOWN   |     | 13d. INSIDE CITY LIMITS?  |              |
| Maryland   |         |   |        | Baltimore   |     | YES <input type="checkbox"/> NO <input type="checkbox"/>                  |              |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |     | 16b. SOCIAL SECURITY NO.  |              |
| Freddie  |         | Della   |        | Yes   |     | 217-14-0242   |              |
|  |         | Bailey  |        |   |     |   |              |
| 17. INFORMANT  |         | ADDRESS   |        | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>LUNG CANCER</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>1629</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 years</u>            |              |
| VAMC medical records, Baltimore, Maryland  |         |   |        |   |     |   |              |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |   |        |   |     |   |              |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?   |     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?            |              |
| 1977   |         | LUNG CARCINOMA  |        | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |     | YES <input type="checkbox"/> NO <input type="checkbox"/>                  |              |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |     |   |              |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |     |   |              |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>October 1, 1980</u> to <u>October 12, 1980</u> , that (X) (we) last saw the deceased alive on <u>October 12, 1980</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) <del>not</del> view the body after death. |         | 22b. SIGNATURE<br><u>Rebecca Moroose MD</u>   |        | 22c. DATE SIGNED<br><u>10/13/80</u>   |     |   |              |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>REBECCA MOROOSE</u>  |         | 22e. ADDRESS<br><u>VAMC, Baltimore, Maryland 21218</u>  |        | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |     |   |              |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>Burial</u>   |         | 23b. DATE<br><u>10/17/80</u>  |        | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cem.</u>  |     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Anne Arundel Co. MD.</u> |              |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm C March F/H</u>  |         | ADDRESS<br><u>1101 E. North Ave.</u>  |        | 25a. DATE REC'D. BY REGISTRAR<br><u>OCT 14 1980</u>   |     | SIGNATURE<br><u>[Signature]</u>   |              |

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DHMH - 17  
(VR A15 ME (5))  
15M 7/76

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                          |  |   |  |  |  |  |  | REG. NO. 25789   |  |
|---|--|--------------------------|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                          |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM R. ROSS</b>  |  |                          |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 23 1980</b> |  | 2b. HOUR <b>M</b>  |  |  |  |
| 3. SEX <b>male</b>  |  | 4. RACE <b>white</b>     |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Oct. 19, 1918</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>62 YRS.</b>                     |  | 7c. DATE PRONOUNCED DEAD <b>10 23 1980</b>   |  | 7d. HOUR <b>10:45 a M</b>  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>   |  |                          |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore City Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>Pa.</b>   |  | 13b. COUNTY <b>Bucks</b> |  | 13c. CITY OR TOWN <b>Quakertown</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>Richland Meadows</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>William R. Ross</b>   |  |                          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Anna Saddington</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>yes</b>  |  |                          |  | 16b. SOCIAL SECURITY NO. <b>WW 2</b>  |  | 17. INFORMANT ADDRESS <b>Mrs. Dorothy G. Ross same</b>                                       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b>   |  |                          |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| IMMEDIATE CAUSE (a) <b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |                          |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |                          |  |   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |                          |  |   |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                          |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                          |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                          |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                          |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                          |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Ann M. Dixon</b>  |  |                          |  | TITLE (SPECIFY) <b>Assistant</b>  |  |  |  | DATE SIGNED <b>10-23-80</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |                          |  | ADDRESS <b>111 Penn St.</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                          |  | 23b. DATE <b>Oct. 28, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Zion Acres Memorial</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Franconia Township Montgomery Pa.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |                          |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1980</b>   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 80 25790<br>REG. NO.   |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CATHERINE H. ROSSO</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>OCT 21 1980</b> 7:35 AM  |  |   |   |
| 3 SEX <b>Female</b>   |  | 4 RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 27 89</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH <b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSP (Mercy)</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>  |   |
| 13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Balto.</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS <b>3747 Bonview Ave.</b>   |  |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Conrad Bauer</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Fiedler</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO. <b>212-74-1232</b>  |  | 17. INFORMANT ADDRESS <b>3687 Kenyon Ave. Lorraine Satterfie 1d (dghtr)</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>5(2) YEARS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>RENAL INSUFFICIENCY 20 TO NEPHROSCLEROSIS</b>   |  |  |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 11 1980</b> to <b>OCT 21 1980</b> , that (I) (we) lost <b>10/21/80</b> saw the deceased alive on <b>OCT 21 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.  |  |  |  |  |  |   |   |
| 22b. SIGNATURE <b>Nelson C. Sun</b> DEGREE  |  |  |  | 22c. DATE SIGNED <b>10/21/80</b>   |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NELSON C. SUN</b>  |  |  |  | 22f. ADDRESS <b>301 ST. PAUL PLACE BALTO MD.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>10/24/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>  |  | 23d. LOCATION <b>Balto.</b> COUNTY STATE  |   |
| 24. FUNERAL DIRECTOR <b>Schmunek Funera l Home, Inc.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |   |

Schmunek Funera l  
Home, Inc.

3331 Brehms Lane  
Balto. Md. 21218

OCT 21 1980

[Signature]



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |                               |   |   |                     |
|---|--|--|--|---|--|--|-------------------------------|---|---|---------------------|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |  |                               |   |   |                     |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |                               |   |   |                     |
| REG. NO. 80 25791   |  |  |  |   |  |  |                               |   |   |                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George C. Rothe  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-11-80              |  |                               |   |   | 2b. HOUR<br>11:15PM |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 11, 1913   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.   |                               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                          |                               |   |   |                     |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Home Corporation |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ship yard        |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel  |   |                     |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   | 13b. COUNTY<br>Baltimore                                     |  | 13c. CITY OR TOWN<br>Eastwood |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Rothe  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Regina Hall |  |                               |   |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-07-4556  |  | 17. INFORMANT<br>ADDRESS<br>21222 LaVerne G. Walker, 8170 Del Haven Rd.   |  |  |                               |   |   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebrovascular Accident<br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atherosclerotic Cardiovascular Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |                               |   |   |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>Hypertension  |  |  |  |   |  |  |                               |   |   |                     |
| 19a. DATE OF OPERATION<br>10-6-80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |                               |   |   |                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                               |   |   |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-6-80, 19 80, to 10-11-80, 19 80, that (I) (we) last saw the deceased alive on 10-11-80, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.           |  |  |  |   |  |  |                               |   |   |                     |
| 22b. SIGNATURE<br>Ynares  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>       |  |  |                               | 22c. DATE SIGNED<br>10-11-80  |   |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. YNARES, MDES   |  |  |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION 100 N. BROADWAY - BALTIMORE, MARYLAND 21231   |  |  |                               |   |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/15/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                    |                               |   |   |                     |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Funeral Home of Dundalk, Inc.   |  |  |  | ADDRESS<br>OCT 14 1980  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980   |                               |   |   |                     |

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United Way Corporation

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1- FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 25792

|  |         |                                 |  |                |  |  |   |  |
|--|---------|---------------------------------|--|----------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                                 | 2a. DATE KNOWN OF DEATH  |                |  | 2b. HOUR   |   |  |
| FIRST MIDDLE LAST<br>Albert Richard Row  |         |                                 | MONTH DAY YEAR<br>10 9 80  |                |  | M  |   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH                | 6. AGE (IN YEARS)  | IF UNDER 1 YR. |  | IF UNDER 24 HRS  |   | 2c. DATE PRONOUNCED DEAD                     |
| Male   | White   | MONTH DAY YEAR<br>June 19, 1947 | 33 YRS.  | MONTHS         | DAYS   | HOURS  | MIN   | MONTH DAY YEAR<br>10 9 80                    |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                                 | 7c. CITIZEN OF WHAT COUNTRY?   |                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| Maryland   |         |                                 | USA  |                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |
| 10. CITY OR TOWN OF DEATH  |         |                                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |  |
| Baltimore  |         |                                 | 22 Mardrew Road  |                |  | Supervisor Construction  |   |  |
| 13a. STATE   |         |                                 | 13b. COUNTY  |                |  | 13c. CITY OR TOWN  |   |  |
| Maryland   |         |                                 | Baltimore  |                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         |                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                |  | 13e. STREET ADDRESS  |   |  |
| Charles E. Row Jr.   |         |                                 | Margaret E. Richardson   |                |  | 22 Mardrew Road 21229  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |                                 | 16b. SOCIAL SECURITY NO.   |                |  | 17. INFORMANT  |   |  |
| Yes  |         |                                 | Viet Nam   |                |  | 5602 Elele Ct. Sykesville, Md. 21784   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: Chlorpromazine intoxication   |         |                                 |  |                |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 9503   |         |                                 |  |                |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                                 |  |                |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |                                 |  |                |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                                 |  |                |  |  |   |  |
| (c)  |         |                                 |  |                |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |                                 |  |                |  |  |   |  |
| 19a. DATE OF OPERATION   |         |                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                |  |  | 20. AUTOPSY?  |  |
|  |         |                                 |  |                |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 10-9- 19 80                                      |                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>self-ingested |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |                                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house                                       |                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>22 Mardrew Rd. Balto, Md.                 |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                                 |  |                |  |  |   |  |
| ACTUAL SIGNATURE   |         |                                 | TITLE (SPECIFY)  |                |  | DATE SIGNED  |   |  |
| Margarita A. Korell, M.D.  |         |                                 | Assistant  |                |  | 10-10-80   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |                                 | ADDRESS  |                |  |  |   |  |
| Margarita A. Korell, M.D.  |         |                                 | 111 Penn Street  |                |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                                 | 23b. DATE  |                | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| Burial   |         |                                 | 10/15/80   |                | Md. Veterans Cemetery Cheltenham   |  | P.G. Md.  |  |
| 24. FUNERAL DIRECTOR NAME  |         |                                 | ADDRESS  |                | 25a. DATE OF DEATH BY  |  | 25b. SIGNATURE  |  |
| MacNabb Funeral Home   |         |                                 | 301 Frederick Rd. Balt., Md. 21228   |                | OCT 14 1980  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |  |  |   |  |
|--|--|---|---|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>ROY ORVILL RULE</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 29, 1980</b> |  |  | 2b HOUR<br><b>12:15 PM</b>   |  |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 26, 1902</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Illinois</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6107 Glen Oak Ave.</b> |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Fireman</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Maryland</b>  |  | 13b COUNTY<br><b>Baltimore</b>  |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>6107 Glen Oak Ave.</b>  |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Rule</b>  |  |   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Watkins</b>  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | (IF YES, GIVE WAR OR DATES)<br><b>WW I</b>  |   | 16b SOCIAL SECURITY NO.<br><b>219-30-0855A</b>   |  | 17 INFORMANT ADDRESS<br><b>Emma M. Rule, 6107 Glen Oak Ave.</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 years</b> |  |   |   |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a I certify that (1) (this hospital) attended the deceased from <b>9/10</b> 19 <b>80</b> , to <b>10/29</b> 19 <b>80</b> , that (1) (we) last saw the deceased alive on <b>9/10</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>David D. Collins, M.D.</b>   |  |   |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>Oct. 30, 1980</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David D. Collins, M.D.</b>  |  |   |   | 22e ADDRESS<br><b>500 W. University Pkwy</b>   |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>Nov. 1, 1980</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rossville, Balto., Md.</b>   |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b><br><b>6009 Harford Rd. Balto., Md. 21214</b>  |  |   |   |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>OCT 31 1980</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>L. J. McQuinn</b>   |  |

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MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |   |                   |  |                     |  |  |                         |  |          |  |
|--|---------|---|-------------------|--|---------------------|--|--|-------------------------|--|----------|--|
| 1. FOR STATE REGISTRAR   |         | 2. DATE KNOWN OF DEATH  |                   | 3. MONTH   |                     | 4. DAY   |  | 5. YEAR                 |  | 6. HOUR  |  |
| 1a. DECEASED NAME (TYPE OR PRINT)  |         | FIRST   |                   | MIDDLE   |                     | LAST   |  | 2a. DATE KNOWN OF DEATH |  | 2b. HOUR |  |
| Alberta  |         | Rush  |                   | 10   |                     | 30   |  | 19                      |  | 80       |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.  | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD   |  | 3. MONTH                |  | 4. DAY   |  |
| female   | black   | 2 6 47  | 33 YRS.           |  |                     | 10 31 1980   |  | 10                      |  | 31 1980  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                         |  |          |  |
| N.Y.   |         | U.S.  |                   |  |                     | Baltimore City   |  |                         |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                         |  |          |  |
| Baltimore  |         | 1801 Popular Grove  |                   |  |                     |  |  |                         |  |          |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         | 13b. COUNTY   |                   | 13c. CITY OR TOWN  |                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS     |  |          |  |
| Md.  |         | Balto.  |                   |  |                     |  |  | 1801 Poplar Grove St.   |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME  |                   |  |                     |  |  |                         |  |          |  |
| FIRST  |         | MIDDLE  |                   | LAST   |                     | FIRST  |  | MIDDLE                  |  | LAST     |  |
| Jessie Hunt  |         | Georgia Dixon   |                   |  |                     |  |  |                         |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT  |                     | ADDRESS  |  |                         |  |          |  |
| no   |         |   |                   | Steven Hunt  |                     | Queens, N.Y.   |  |                         |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                   |  |                     |  |  |                         |  |          |  |
| PART 1 DEATH WAS CAUSED BY:  |         |   |                   |  |                     |  |  |                         |  |          |  |
| IMMEDIATE CAUSE (a)  |         | Acute ethanol intoxication  |                   |  |                     |  |  |                         |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |  |                     |  |  |                         |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         | (b)   |                   |  |                     |  |  |                         |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |  |                     |  |  |                         |  |          |  |
| (c)  |         |   |                   |  |                     |  |  |                         |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |                   |  |                     |  |  |                         |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   | 20. AUTOPSY?   |                     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |                         |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                     |  |  |                         |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                     |  |  |                         |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | TITLE (SPECIFY)   |                   | DATE SIGNED  |                     | 10/31/80   |  |                         |  |          |  |
| ACTUAL SIGNATURE   |         | Hormez R. Guard, M.D.   |                   | MEDICAL EXAMINER   |                     |  |  |                         |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |                   | 111 Penn Street, Balto., MD 21201  |                     |  |  |                         |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                     | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |                         |  |          |  |
| Burial   |         | 11/4/80   |                   | Mt. Auburn   |                     | Balto. Md.   |  |                         |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |         | ADDRESS   |                   | 25a. DATE REC'D. BY REGISTRAR  |                     | 25b. REGISTRAR'S SIGNATURE   |  |                         |  |          |  |
| Wainwright   |         | 2700 Edmondson Ave  |                   | NOV 3 1980   |                     | L. H. H. H. H.   |  |                         |  |          |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                  |   |   |   |  |  |   |   |
|--|------------------|---|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CARROLL WAYNE RUSH  |                  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH 10 DAY 5 YEAR 80        |   |  | 2b. HOUR<br>M 12:45  |   |   |
| 3. SEX<br>male   | 4. RACE<br>white | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 29, 1952   | 6. AGE (IN YEARS)<br>LAST F. (11/24)<br>27 YRS.                       | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10 5 80                      |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, MD.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>200 blk. S. Light St. |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Empl.       |
| 13a. STATE<br>MD.  |                  |   | 13b. CITY OR TOWN<br>Anne Arundel                                     |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        | 13d. STREET ADDRESS<br>7823 B&A Blvd.                                      |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry K. Rush  |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Helen Viers     |   |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>YES   |                  |   | 16b. SOCIAL SECURITY NO.<br>1971-1975                                 |   | 17. INFORMANT (wife) ADDRESS<br>Mrs. Frances E. Rush same as # 13                                      |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>9654 IMMEDIATE CAUSE (a) Gunshot wound of chest (unspecified weapon)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |   |   |   |  |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |   |   |   |  |  |   |   |
| 19a. DATE OF OPERATION   |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>xxx 10-5-80        |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Shot during argument. |  |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>200 blk. S. Light St., Balto. MD.                 |  |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |   |   |   |  |  |   |   |
| ACTUAL SIGNATURE<br><i>Ann M. Dixon</i>  |                  |   | M.D. Assistant  |   |  | DATE SIGNED 10-5-80  |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  |   | ADDRESS<br>111 Penn St.   |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  |   | 23b. DATE<br>Oct. 9, 1980   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. MD.                  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home   |                  |   | ADDRESS<br>Glen Burnie, MD.   |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 7 1980                                |   | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony Halbrudy</i> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 9 6  
REG. NO.

|   |  |  |   |   |                                     |  |   |   |  |  |
|---|--|--|---|---|-------------------------------------|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Mary Helen Rush</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>October 18, 1980</i>          |   |                                     | 2b. HOUR<br>a.m. p.m.<br><i>5 15 a.m.</i>  |   |   |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>white</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 28 88</i>   |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>91</i> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Caton Manor Nursing Center</i> |   |   |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>seamstress</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>retail store</i>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Maryland</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>   |   | 13c. CITY OR TOWN<br><i>Arbutus</i> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><i>5201 Benson Ave.</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George H. Albiken</i>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Englehardt</i> |   |                                     |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>n/a</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>212-07-5702</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Caton Manor Nursing Center Chart</i>   |                                     |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>4292 Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arteriosclerotic CVD, advanced</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>   |  |  |   |   |                                     |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>Pneumonitis</i>  |  |  |   |   |                                     |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                     |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                     |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 10/17</i> 19 <i>80</i> to <i>10/18</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10/17</i> 19 <i>80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) did (did not) view the body after death. |  |  |   |   |                                     |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Herbert J. Levickas</i>  |  |  |   | DEGREE<br><i>M.D.</i>   |                                     | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>10/20/80</i>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Herbert J. Levickas</i>   |  |  |   | 22e. ADDRESS<br><i>5404 East Drive Arbutus, Md. 21227</i>   |                                     |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>10/21/80</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park Cemetery</i>   |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City Maryland</i>   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Ambrose Funeral Home Inc. 1328 Sulphur Spring Rd.</i>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 21 1980</i>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><i>Esther McCreedy</i>   |   |   |  |  |

Constitution of the United States

Article I

Section 1  
All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8025797   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MILRDED</b>   |  |   |  | FIRST<br><b>RUSSELL</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 9, 1980</b>  |  | 2b. HOUR<br><b>9:04a</b>                        |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 4 33</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b>                              |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>   |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>MD</b>      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>             |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore Co. General</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>9717 Mendoza Rd.</b>                            |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Norhert Lee</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eleanor Butler</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-30-5713</b>  |  | 17. INFORMANT ADDRESS<br><b>Marvin Russell 9717 Mendoza Rd.</b>   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Breast Carcinoma</b>  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> to <b>present</b> 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Oct 8</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Marvin Russell</i>   |  |   |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marvin Russell</b>  |  |   |  | 22e. ADDRESS  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/14/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore CA MD</b>      |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1980</b>                       |  |  |  |   |  |

0501 4 1 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please fill out and retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  | REG. NO. 80 25198   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>TOMMY G.B. RUSSELL</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>6</b> YEAR <b>80</b>                    |  |  | 2b. HOUR <b>4:27 P.M.</b>   |  |   |  |
| 3 SEX <b>M</b>   |  | 4 RACE <b>W</b>  |  | 5 DATE OF BIRTH MONTH <b>7</b> DAY <b>11</b> YEAR <b>21</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.  |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>                                       |  | IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY</b> MD.                                   |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH <b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NORTH CHARLES GEN HOSP</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERINTENDENT</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>PAINT CO.</b>                                |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |   |  |   |  |
| 13a. STATE <b>M.D.</b>   |  | 13b. COUNTY <b></b>  |  | 13c. CITY OR TOWN <b>BALTO.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>21 YORK CT.</b>  |  |   |  |
| 14 FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b></b> LAST <b>RUSSELL</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>EVA</b> MIDDLE <b>PEARL</b> LAST <b>BISHOP</b> |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>WWII</b> <b>240 206332</b>   |  | 17 INFORMANT ADDRESS <b>MRS BESSIE I. RUSSELL SAME</b>                                       |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVP</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>  |  |  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>8-25</b> , 19 <b>80</b> , to <b>10-6</b> , 19 <b>80</b> , that (he) (we) lost saw the deceased alive on <b>10/6/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>David Strobel</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |  |  |  |  | 22c. DATE SIGNED <b>10-6-80</b>  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID STROBEL</b>   |  |  |  |  |  | 22e. ADDRESS <b>N.C.G. H.</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  | 23b. DATE <b>10/9/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>  |  | 23d. LOCATION CITY OR TOWN <b>Pikesville,</b> COUNTY <b>Md.</b> STATE <b></b>     |  |   |  |
| 24 FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 7 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                     |  |   |  |

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400 York Road, Baltimore, Md. 21212  
Burial Henry W. Johnson  
to 10/20/80  
Gruid Pigeon  
Pikesville, Md.

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100 100 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after issue. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 7 9 9

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ABRAHAM MILO SACHS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 14 80</b> |   |  | 2b. HOUR<br><b>1134 A M</b>   |  |  |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 21, 1907</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>   |  | 7. AGE (IN YEARS LAST BIRTHDAY)<br># UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PHARMACIST</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DRUGS</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>APT. 514<br/>4001 CLARKS LA. #21215</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MICHAEL SACHS</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>HATTIE SANDLER</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO<br><b>220-30-5291</b>  |  | 17. INFORMANT <b>MRS. SADIE SACHS</b><br><b>4001 CLARKS LA., APT. 514 BALTO., MD 21215</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b><br><b>410 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>AS LVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 hrs</b><br><b>10 yrs</b> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>W</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>W</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>W P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>W</b>  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>W</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>412 19 60 10/14 80</b>  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>above, (I) (we) (did) (did not) view the body after death.<br><b>10/14 19 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Maurice Feldman</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>10/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAURICE FELDMAN, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>6610 CROSS COUNTRY BLVD</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>OCT. 16, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ANSHE EMUNAH</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>R. J. McCready</b>   |  |  |  |



26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  |   |  | 2b. HOUR   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| DAVID  |  |  |  | SALMON d   |  |   |  | 10 8 80 10:15Am  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |  |
| MALE   |  | BLACK  |  | 9 30 34  |  | 46 YRS.   |  | MONTHS   |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| SOUTH CAROLINA   |  | U.S.A.   |  |  |  | BALTIMORE CITY MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| BALTIMORE  |  | VA MEDICAL CENTER BALTO.MD.  |  |  |  |   |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| MARYLAND   |  | BALTO  |  | BALTIMORE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 10917 HUNTCLIFF ROAD 21117                                     |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |
| BOYKIN   |  |  |  | LAURA  |  |   |  | LEWIS  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |  |  |  |  |
| YES  |  |  |  | KOREAN   |  | Boykin Salmond Jr. 1319 N. Montford                                 |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  | 11/76  |  |
| IMMEDIATE CAUSE (a) <del>SEP</del> Cardio-Respiratory arrest, sepsis   |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Bladder Carcinoma  |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 7/23/80  |  | Nephrostomy Tube   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |  |  |  |
|  |  | 10:15 P.M. OCT 8 1980  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 17, 1980, to OCT. 8, 1980, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on OCT. 8, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |  |  |
| C. Rosenbaum MD  |  |  |  |  |  |   |  | 10/8/80  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |  |  |  |  |
| C. Rosenbaum, M.D.   |  |  |  | 3900 LOCH RAVEN BLVD. BALTO. MD. 21218   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. COUNTY  |  |  |  |
| Burial   |  | 10/11/80   |  | Baltimore Cem.   |  | Baltimore   |  | MD   |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |
| Wm. C. March F/H 1101 E. North Ave.  |  |  |  | OCT 10 1980  |  |   |  | [Signature]  |  |  |  |



*Handwritten signature*

OCT 10 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

## MEDICAL CERTIFICATION

|  |  |   |  |  |                 |   |            |   |            |   |  |
|--|--|---|--|--|-----------------|---|------------|---|------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Gerald   |  | MIDDLE<br>Marion   | LAST<br>Senders | 2a. DATE OF DEATH<br>MONTH<br>10  |            | DAY<br>9  | YEAR<br>80 | 2b. HOUR<br>12:30 PM                                  |  |
| 3. SEX<br>male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH<br>10  |                 | DAY<br>8  | YEAR<br>80 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>1 day  |            | 7. IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md., U.S.A.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City  |            |   |            |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Johns Hopkins Hospital |  |  |                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N/A                         |            | 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A  |            |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balt. City   |  | 13c. CITY OR TOWN<br>Balt.   |                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |            | 13e. STREET ADDRESS<br>1238 Decker Ave  |            |   |  |
| 14. FATHER'S NAME<br>FIRST<br>Gerald   |  | MIDDLE<br>E.  |  | LAST<br>West   |                 | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Doreen   |            | MIDDLE<br>Senders   |            | LAST<br>Senders                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |  | 17. INFORMANT<br>ADDRESS<br>Delores Lassiter 1323 N. Milton Avenue   |                 |   |            |   |            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>7485<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congenital pulmonary hypoplasia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |                 |   |            |   |            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |  |                 |   |            |   |            |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |            | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |            |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |                 |   |            |   |            |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE   |                 |   |            |   |            |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/8</u> , 19 <u>80</u> , to <u>10/9</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/9</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |                 |   |            |   |            |   |  |
| 22b. SIGNATURE<br>Richard A. Moltani   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                 |   |            | 22c. DATE SIGNED<br>10/9/80   |            |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD A. MOLTANI  |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL ISCU  |                 |   |            |   |            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/13/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park   |                 | 23d. LOCATION<br>CITY OR TOWN<br>Randallstown, Maryland   |            | STATE   |            |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March Funeral Home/1101 E. North Ave.   |  |   |  | ADDRESS<br>1101 E. North Ave.  |                 | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |            | 25b. REGISTERED SIGNATURE<br>Ricky Hebert   |            |   |  |

*Handwritten signature*

OCT 14 1980

CHIEF OF POLICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 5 8 0 2   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Charles James Sank  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10/19/80  |  | 2b. HOUR<br>3:40 P.M.  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8/28/14  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST AGNES HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>COMMISSIONED   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOSPITAL -  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13b. STREET ADDRESS   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>--   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Marcellis Sank   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Helen Unknown   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>WW II 218-03-9870   |  | 17. INFORMANT ADDRESS<br>Betty A. Sank 2502 Banger Street, 21230  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEVERE COPD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>MASS L LUNG PROB CARCINOMA</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 DAYS<br>5 YRS<br>1 MONTH |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>UPPER GI BLEEDING. PROB 2° TO PEPTIC ULCER DISEASE.</u>   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 14</u> , 19 <u>80</u> , to <u>OCT 19</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>OCT 19</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>ANASTACIO R. DE CASTRO</u>  |  |   |  | 22e. ADDRESS<br>900 CATON AVE BALTIMORE MD 21229  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10-23-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge Howard Maryland   |  |
| 24. FUNERAL DIRECTOR NAME<br>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>21229<br>OCT 21 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

RECEIVED

BALTIMORE CITY

ST. JOSEPH HOSPITAL

BALTIMORE

1000 COLUMBIA AVENUE BALTIMORE MD 21205

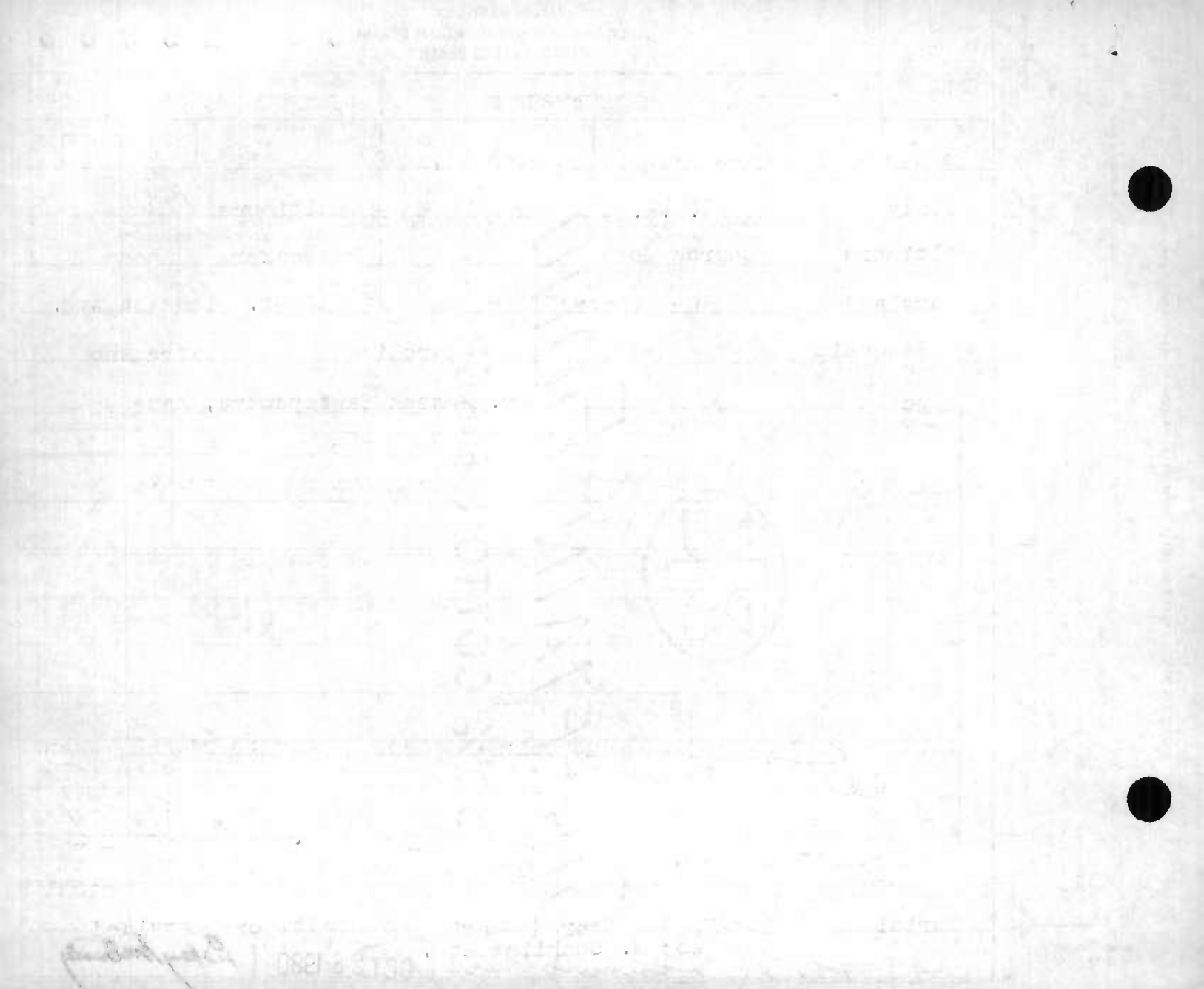
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 8 0 3  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |  |
| ANGELINA SANTAVENERE  |  | OCTOBER 24, 1980   |  |
| 3. SEX  |  | 4. RACE  |  |
| Female  |  | Caucasian  |  |
| 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| March 21, 1898  |  | 82 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| Italy   |  | Italy  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
|   |  | Baltimore  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Baltimore   |  | Church Home  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| homemaker   |  | home   |  |
| 13a. STATE  |  | 13b. COUNTY  |  |
| Maryland  |  |  |  |
| 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  |
| Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| Pasquale  |  | Carolina   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |
| no  |  |  |  |
| 17. INFORMANT   |  | ADDRESS  |  |
| Mr. Joseph Santavenera, same  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ACUTE MYOCARDIAL INFARCTION   |  |  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |
| 410 -   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c)   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
|   |  |  |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |
|   |  | P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED   |  |
|   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |
|   |  | 21f. LOCATION  |  |
|   |  | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) this hospital attended the deceased from OCTOBER 19, 19 80 to OCTOBER 24, 19 80, that (I) (we) lost saw the deceased alive on OCTOBER 24, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |
| A. F. Nazemi M.D.   |  | 1980-24-808  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| A. F. NAZEMI, M.D.  |  | CHURCH HOSPITAL CORPORATION  |  |
|   |  | 100 N. BROADWAY, BALTIMORE, MD 21201   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  |
| Burial  |  | 10/27/80   |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Sacred Heart  |  | Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Joseph N. Lannert   |  | OCT 28 1980  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |   |   |  |  |   |  |
|--|--|---|--|---|---|---|--|--|---|--|
| 8 0 2 5 8 0 4<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |   |  |
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | REG. NO.  |   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Pearl V. Sauerwald   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/8/80  |   |  | 2b. HOUR<br>M  |   |  |
| 3. SEX<br>female   |  | 4. RACE<br>Cauc.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/12/06   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                                  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                     |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>909 W. 34th. St. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>Md.  |  |   |  |   | 13b. COUNTY<br>---  |   | 13c. CITY OR TOWN<br>Balto.                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>? ? ?  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>? ? ?  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---         |   | 17. INFORMANT<br>bcpd   |   |  | ADDRESS  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the Lung</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 months |  |   |  |   |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>80</u> , to <u>Oct</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.   |  |   |  |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br>Sheldon Goldgeier M.D. DEGREE  |  |   |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>10/8/80  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>sheldon Goldgeier   |  |   |  |   | 22e. ADDRESS<br>711 W. 40th St. 21211   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>10/10/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Pk.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Paul E. Chenoweth 3rd. 3617 Chestnut Ave.   |  |   |  |   | 25a. DATE RECEIVED BY REGISTRAR<br>OCT 10 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires, that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 7a g549 11/19/80 gj

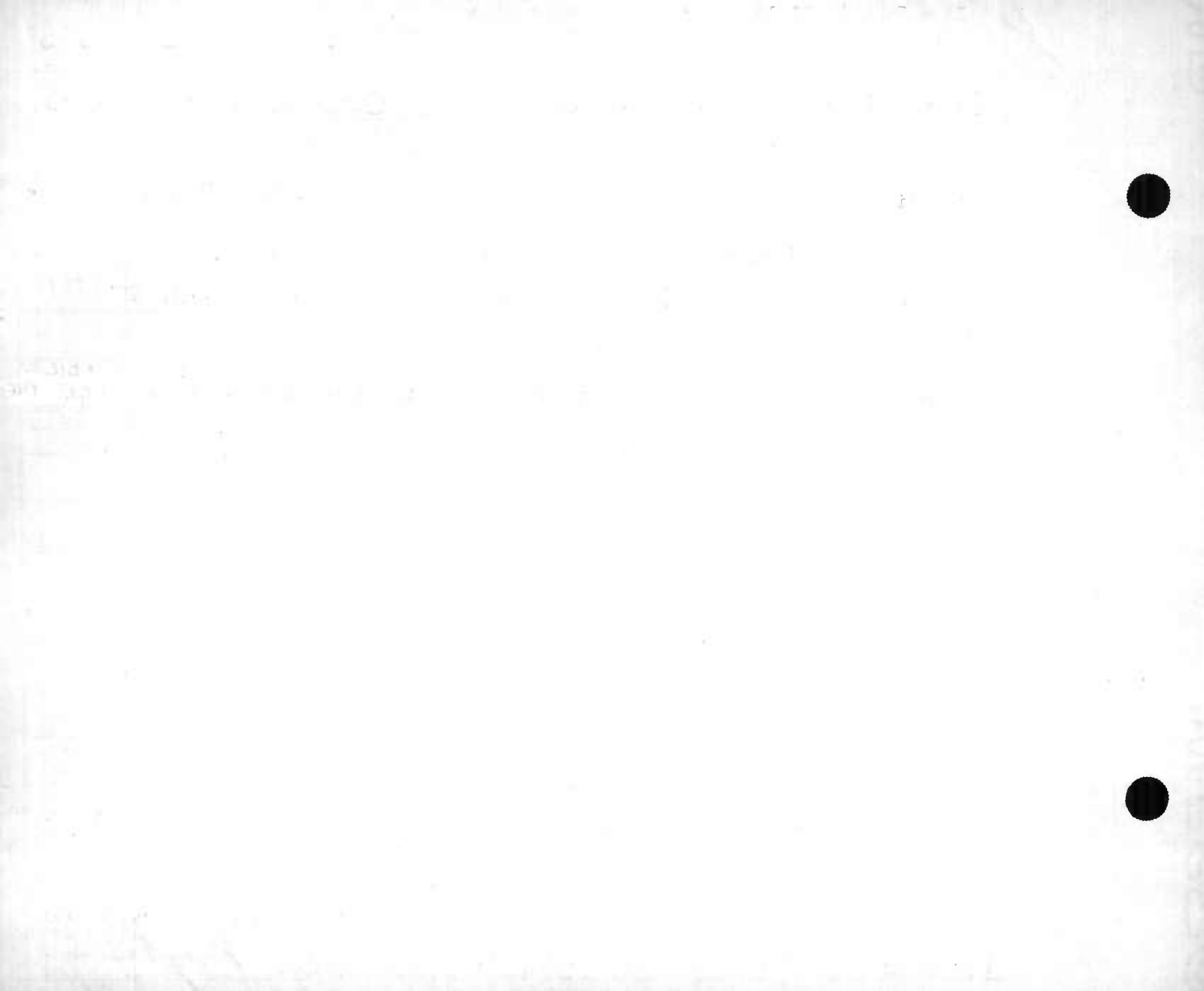
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25805

REG. NO.

1- STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>OAKLEY H. SAUNDERS SR.</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 18 1980</b> |  |  | 2b HOUR<br><b>3:10 A.M.</b>  |  |   |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>Black</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 20 1897</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore MD</b>  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pleasant Manor Nursing Home</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>BALTIMORE</b>   |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS<br><b>1003 W. 43RD ST #11</b>  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>TOM SAUNDERS</b>   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b SOCIAL SECURITY NO<br><b>225-01-9410</b>   |  | 17 INFORMANT<br><b>MRS. BEATRICE E. SAUNDERS</b>   |  | ADDRESS<br><b>1003 W. 43 RD. ST. BALTO, MD.</b>  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure 2°b ASCVD</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic CV Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9/18/80</b><br><b>6/80</b> |  |  |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a<br><b>EVA - Rt. Hemiparesis</b>   |  |  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22 I certify that (I) (this hospital) attended the deceased from <b>9/18</b> 19 <b>80</b> to <b>10/17</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10-17</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>Jammi Pungolar</b><br>22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10-18-80</b>   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10/22/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Deborah E. Witter</b><br>ADDRESS<br><b>-3035 W. North Ave.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ricky K. K...</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |                                    |  |   |                           |   | 8 0 2 5 8 0 6 |  |  |
|---|--|--|--|---|------------------------------------|--|---|---------------------------|---|---------------|--|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.   |   |                                    |  |   |                           |   |               |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |   |                                    | 2a. DATE OF DEATH  |   |                           | MONTH DAY YEAR  |               | 2b. HOUR                                     |  |
| HELEN B. SAVAGE   |  |  |  |   |                                    | 10 20 80   |   |                           | 6 55  |               | A M  |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH  |                                    |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |                           | IF UNDER 1 YEAR   |               | IF UNDER 24 HRS                              |  |
| Female  |  | Black  |  | MONTH DAY YEAR<br>5 10 10   |                                    |  | 70  |                           | MONTHS DAYS   |               | HOURS MIN                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                           |   |               |  |  |
| VA  |  | USA  |  |   |                                    |  | CITY MD.  |                           |   |               |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |                                    |  |   |                           |   |               |  |  |
| BALTO   |  | SINAI  |  |   |                                    |  |   |                           |   |               |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |                                    |  |   |                           |   |               |  |  |
| Wm. pro. 48   |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET ADDRESS       |   |               |  |  |
| MD.   |  | BALTO  |  | BALTO   |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 3 800 W. Belvedere Av.    |   |               |  |  |
| 14 FATHER'S NAME  |  |  |  | 15 MOTHER'S MAIDEN NAME   |                                    |  |   |                           |   |               |  |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST   |                                    |  |   |                           |   |               |  |  |
| Cutler  |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |                                    | 17 INFORMANT ADDRESS   |   |                           |   |               |  |  |
| No  |  |  |  | 219-22-0572   |                                    | Annie B. Neal 3603 Reisterstown Rd.  |   |                           |   |               |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY   |  |  |  |   |                                    |  |   |                           |   |               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) 5719 ? septic shock   |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEPTIS   |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC Liver/Heart Disease  |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| SEVERE Hypocalemia - ? MENINGITIS ?   |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |                                    |  | 20a. AUTOPSY?   |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |               |  |  |
|   |  |  |  |   |                                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |               |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                           |   |               |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |                                    |  |   |                           |   |               |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |                                    | 21f. LOCATION  |   |                           |   |               |  |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  |   |                                    | STREET CITY OR TOWN COUNTY STATE   |   |                           |   |               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19/80 to 10/26/80, that (I) (we) last saw the deceased alive on 10/26/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |   |                                    |  |   |                           |   |               |  |  |
| [Signature]   |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| 22c. DATE SIGNED  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |                                    |  |   |                           |   |               |  |  |
| 10/26/80  |  |  |  |   |                                    |  |   |                           |   |               |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |   |                                    |  |   |                           |   |               |  |  |
| Wilvise E. Downing  |  |  | SINAI Hospital   |   |                                    |  |   |                           |   |               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION             |   |               |  |  |
| Burial  |  |  | 10/31/80   |   | King Memorial Pk.                  |  |   | CITY OR TOWN COUNTY STATE |   |               |  |  |
| Baltimore   |  |  |  |   |                                    |  |   | MD                        |   |               |  |  |
| 24 FUNERAL DIRECTOR NAME  |  |  |  |   |                                    | 24b. ADDRESS   |   |                           | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE             |               |  |  |
| Wm. C. March f/h  |  |  |  |   |                                    | 1101 E. North Ave.   |   |                           | OCT 28 1980   |               |  |  |

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 80 25807<br>REG. NO.   |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 1. DECEASED NAME FIRST MIDDLE LAST<br>Betty SAVILLE  |  |  |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br>10/8/80 8 32 04  |  |   |  | 2b. HOUR<br>5:25 AM  |  |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>9 12 04   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ireland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Catonsville   |  | 13c. STREET ADDRESS<br>213 N. Beachwood Avenue   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Jerry O'Leary  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Cahill   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-70-0550  |  | 17 INFORMANT ADDRESS<br>John R. Saville Catonsville, Maryland  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest -</u><br>4241<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Valvulopathy, Aortic Insufficiency</u><br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Hypertension</u> |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>October 7, 1980</u> to <u>October 8, 1980</u> , that (I) (we) lost saw the deceased alive on <u>October 8, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Bich T Duong</u> DEGREE<br>M.D.   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  | 22c. DATE SIGNED<br>10/8/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BICH T DUONG  |  |   |  | 22e. ADDRESS<br>ST AGNES HOSPITAL<br>900 CATON AVE. BALTIMORE, MD. 21229   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Oct. 10, '80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Asbury Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baker, West Virginia   |  |
| 24 FUNERAL DIRECTOR NAME<br>William E. Johnson   |  |   |  | ADDRESS<br>8521 Loch Raven Blvd.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980   |  |
|  |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>R. J. Johnson</u>   |  |

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

BALTIMORE CITY

ST. AGNES HOSPITAL

BALTIMORE

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

SEP 11 1980

TO : DIRECTOR, FBI (100-441100)  
FROM : SAC, BALTIMORE (100-100000)  
SUBJECT: [Illegible]  
DATE: 9/11/80  
RE: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   |  |   |  |  |                      |
|---|--|--|--|--|---|--|---|--|--|----------------------|
| 1. FOR STATE REGISTRAR  |  |  |  |  |   |  |   |  |  |                      |
| 1. DECEASED NAME (TYPE OR PRINT)<br>George L. Schabdach   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10-10-80              |  |   |  |  | 2b. HOUR<br>11:52 PM |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>August 8 1897  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |                      |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balto. G. & E.  |  |                      |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Timonium  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br>9 G. Misty Wood Circle  |  |                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Leonard Schabdach   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elaine T. Schwabe   |   |  |   |  |  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-05-5097   |  | 17. INFORMANT ADDRESS<br>Paul M. Horn, Same As #13e  |   |  |   |  |  |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory and Cardiac Arrest</u><br>411-<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Coronary Insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |   |  |  |                      |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |                      |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-09</u> , 19 <u>80</u> , to <u>10-10</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |  |   |  |   |  |  |                      |
| 22b. SIGNATURE<br><u>Christine L. Kirkwood, M.D.</u>  |  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>10-10-80   |  |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Christine L. Kirkwood, M.D.</u>   |  |  |  |  |   | 22e. ADDRESS<br><u>Union Memorial Hospital</u>   |   |  |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Entombment   |  |  | 23b. DATE<br>10-14-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Maus. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Woodlawn Balto. Md. |  |  |                      |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |  |  |                      |

Christine L. Johnson, M.D., Director

Medical Staff

Chief of Staff, Dr. [illegible]

Baltimore City (John Memorial Hospital)

Baltimore City

Scholarship

Report

1957-58

May 1958

Page

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 0 9

REG. NO.

|   |         |   |        |   |          |   |   |                                 |
|---|---------|---|--------|---|----------|---|---|---------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |         | 2a. DATE OF DEATH   |        | MONTH   | DAY      | YEAR  | 2b. HOUR  |                                 |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   | MIDDLE | LAST  | 10 29 80 |   |   | 11:25 <sup>P</sup> <sub>M</sub> |
| Anna  |         | A. M.   |        | SCHAEFER  |          |   |   |                                 |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS LAST BIRTHDAY)   |          | 7. IF UNDER 1 YEAR  |   |                                 |
| Female  | White   | MONTH DAY YEAR<br>11 09 11  |        | 68 6-9 YRS  |          | IF UNDER 24 HRS   |   |                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |                                 |
| Illinois  |         | U.S.A.  |        | BALTIMORE CITY  |          | MD  |   |                                 |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |                                 |
| BALTIMORE   |         | ST AGNES HOSPITAL   |        | Seamstress  |          | Clothing  |   |                                 |
| 13a. STATE  |         | 13b. COUNTY   |        | 13c. CITY OR TOWN   |          | 13d. INSIDE CITY LIMITS?  |   |                                 |
| Md.   |         |   |        | Baltimore   |          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                                 |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME  |        | 13e. STREET ADDRESS   |          |   |   |                                 |
| FIRST MIDDLE LAST<br>Joseph Houdek  |         | FIRST MIDDLE LAST<br>Mary Buckta  |        | 2904 Mall View Rd.  |          |   |   |                                 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |          | ADDRESS   |   |                                 |
| No  |         | 216-28-9320   |        | Kenneth J. Frome  |          | 429 Fifth Ave. Balto. Md.   |   |                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Pericardial effusion &amp; pericardial tamponade</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Haser, CHF</u>  |         |   |        |   |          |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Collateral vein thrombosis &amp; pulmonary embolism</u>   |         |   |        |   |          |   |   |                                 |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?   |          | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |   |                                 |
|   |         |   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |          | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |                                 |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |          |   |   |                                 |
|   |         |   |        |   |          |   |   |                                 |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |          |   |   |                                 |
|   |         |   |        |   |          |   |   |                                 |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/19/80</u> 19 <u>11:29</u> , to <u>10/29/80</u> 19 <u>11:29</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/19/80</u> 19 <u>11:29</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |         |   |        |   |          |   |   |                                 |
| 22b. SIGNATURE  |         | DEGREE  |        | 22c. DATE SIGNED  |          |   |   |                                 |
| <u>Dr. Navarro</u>  |         |   |        | <u>10/29/80</u>   |          |   |   |                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         | 22e. ADDRESS  |        | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |          |   |   |                                 |
| DR. NAVARRO   |         |   |        |   |          |   |   |                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |   |                                 |
| Burial  |         | Nov. 1, 1980  |        | Loudon Park   |          | Baltimore, Md.  |   |                                 |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |         |   |        | 25a. DATE REC'D. BY REGISTRAR   |          | 25b. REGISTRAR'S SIGNATURE  |   |                                 |
| McGully Funeral Home 237 E. Patapsco Ave.   |         |   |        | OCT 31 1980   |          | <u>Anthony A. Brady</u>   |   |                                 |



BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

RECEIVED  
JAN 10 1942

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 0 2 5 8 1 0  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1 - STATE REGISTRAR   |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>DOROTHY SCHAUERMANN</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 2 80</b>  |  | 2b. HOUR<br><b>3:30</b> A.M.   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 25 14</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MO.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John J. Schauermann</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie CO WMAN</b>  |  | 13e. STREET ADDRESS<br><b>3939 Roland Ave # 313</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-18-9224</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>PATIENT</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Myocardial Infarction</b><br>(c) <b>Pulmonary Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-25</b> , 19 <b>80</b> , to <b>10-2</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10-2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C.R. Kirkwood MD</b>   |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10-2-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Christine L. Kirkwood M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>10/2/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>  |  |   |  | ADDRESS<br><b>Balto., Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 3 1980</b>   |  |
|   |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Christine L. Kirkwood</i>   |  |

1307 BP

Hospital

Clark

1000

Wells

Schneidman

3

John

1000

Remove

Police, No.

Sharon Board

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH A. SCHETTINO</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 24, 1980</b>            |  | 2b. HOUR P.M.<br><b>4:30</b>   |   |  |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>WHITE</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>MAY 19, 1898</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 <b>BALTIMORE CITY</b> OR COUNTY OF DEATH MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6012 BERTRAM AVENUE 21214</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>BARTENDER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BAR</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6012 BERTRAM AVENUE 21214</b>                        |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DONATO SCHETTINO</b>   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GIACONDA CHAMPI</b> |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>160 10 5606</b>   |  | 17. INFORMANT ADDRESS<br><b>ANNAMARIE ENDRES 6012 BERTRAM AVE. BALTO MD.</b>   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>Severe Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 wks.</b><br><b>3 yrs.</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-1</b> , 19 <b>79</b> , to <b>10-24</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10-24</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Jaime Punzalan</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br><b>10/25/1980</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAIME PUNZALAN</b>   |  |   |  | 22e. ADDRESS<br><b>5214 Harford rd. Balto. Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10/27/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE BALTO. MARYLAND</b>                  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>DIPPEL FUNERAL HOME 7110 BELAIR RD. BALTIMORE MD.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>History McLeod</b>   |  |  |  |

WPI

100-10-2466

082-17510-2

**NAME:** John Schlee

**DATE OF DEATH:** October 25, 1980

**PLACE OF DEATH:** Baltimore City

**SEE:** #80-25821  
Baltimore City

DHM 2485 - Vit. Rec.

W. H. G. R. O. V. E. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |   |  | 8  | 0 | 2 | 5 | 8                                    | 1 | 2 |
|---|--|---|--|---|--|---|--|---|--|--|---|---|---|--------------------------------------|---|---|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |   |  | REG. NO.   |   |   |   |                                      |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Vernon George Schlipper</b><br><i><del>George Vernon Schlipper</del></i>   |  |   |  |   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/17/80</b>               |   |   |   | 2b. HOUR<br><b>10<sup>25</sup> A</b> |   |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 21 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.                                    |   |   |   |                                      |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |  |   |   |   |                                      |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>American Can</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Co.</b>   |  |  |   |   |   |                                      |   |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3518 Frankford Avenue</b>   |  |  |   |   |   |                                      |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Schlipper</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace Brennan</b>   |  |   |  |   |  |  |   |   |   |                                      |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Richard Floyd</b>   |  | 7825 East Collingham Dr.<br>Balto. MD 21222   |  |   |  |  |   |   |   |                                      |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b><br><b>4/15/1</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cachexia</b>   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>15 minutes</b> |   |   |   |                                      |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |  |   |  |  |   |   |   |                                      |   |   |
| 19a. DATE OF OPERATION<br><b>NONE</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |   |   |                                      |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |  |   |   |   |                                      |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |   |   |   |                                      |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/10/80</b> , 19____, to <b>10/17/80</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>10/17/80</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |   |   |   |                                      |   |   |
| 22b. SIGNATURE<br><b>PA GORALSKI</b><br>DEGREE <b>MD</b>  |  |   |  |   |  |   |  |   |  | 22c. DATE SIGNED<br><b>10/17/80</b>                                  |   |   |   |                                      |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PA GORALSKI</b>   |  |   |  |   |  |   |  |   |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>                       |   |   |   |                                      |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/21/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Mem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Marsh, Balto., MD</b>                    |  |   |  |  |   |   |   |                                      |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McCreedy</i>   |  |  |   |   |   |                                      |   |   |

MEDICAL CERTIFICATION



10-25-1954

21

Washington, D.C.

Union Memorial Hospital

Washington



10-25-1954

Mr. C. J. ...

10-25-1954

10-25-1954

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 0 2 5 8 1 3

REG. NO.

|   |  |   |  |   |   |  |                                       |   |   |  |
|---|--|---|--|---|---|--|---------------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lester A. Schloss</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 11 / 80</b>          |   |   | 2b. HOUR<br><b>8:35 P.M.</b>   |                                       |   |   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 24 94</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |                                       |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sinai Hospital of Baltimore</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>   |                                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Oil Company</b>   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b>  |  |   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b> |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                             |  |                                       |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>216-01-8038</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Lester A. Schloss, Jr 5709 Harford Rd.</b> |  |                                       |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of larynx</b><br>1619<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ |  |   |  |   |   |  |                                       |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                                       |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                       |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>September 11, 1980</b> , to <b>October 11, 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>October 11, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |                                       |   |   |  |
| 22b. SIGNATURE<br><b>Diana Rivera-Cestero</b>   |  |   | DEGREE<br><b>MD</b>  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                       |   | 22c. DATE SIGNED<br><b>10/11/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Diana Rivera-Cestero</b>  |  |   | 22e. ADDRESS<br><b>Sinai Hospital of Baltimore</b>                     |   |   |  |                                       |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>cremation</b>  |  |   | 23b. DATE<br><b>10/13/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Memorial</b>            |  |                                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Westview Baltimore, Md</b>   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ambrose Funeral Home Inc.</b>  |  |   | ADDRESS<br><b>1328 S. Phur Sp. Rd.</b>                                 |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |                                       | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

*[Vertical handwritten text on the right margin:]*  
DIRECTOR  
MAY 1964  
1111  
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 1 4

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |  |  |   |  |  |                             |  |
|---|--|--|--|--|--|--|--|---|--|--|-----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>DORA</b>   |  |  | FIRST MIDDLE LAST <b>SCHLOSSENBERG</b> |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 9, 1980</b>                                      |  |   | 2b. HOUR <b>10:40 AM</b>                         |  |                             |  |
| 3 SEX <b>FEMALE</b>   |  | 4 RACE <b>CAUCASIAN</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>MARCH 16 1902</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.  |  |   | IF UNDER 1 YEAR MONTHS DAYS                      |  | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ENGLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.                               |  |   |  |  |                             |  |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINTALE HEBREW GERIATRIC CENTER - HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>               |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b> |  |                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b> 13c. COUNTY <b>BALTO.</b> |  |  |  | 13d. CITY OR TOWN <b>BALTIMORE</b>   |  | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13f. STREET ADDRESS <b>114 WALDRON AVE. 21208</b> |  |  |                             |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>MEYER DANTZIC</b>   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LEAH UNKNOWN</b>  |  |  |  |   |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>214-11-0900</b><br><b>214-14-9500</b>  |  | 17 INFORMANT <b>MR. VICTOR SCHLOSSENBERG</b><br><b>114 WALDRON AVE. BALTO., MD 21208</b>     |  |   |  |  |                             |  |

|   |  |  |  |
|---|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/20 1980</b><br>P.M. 19 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 22a. I certify that (he) (this hospital) attended the deceased from <b>10/9</b> <b>4/20</b> 19 <b>78</b> , to <b>10/9</b> 19 <b>80</b> , that (we) last saw the deceased alive on <b>10/9</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>E. K.</b>   |  |  |  | DEGREE   |  | 22c. DATE SIGNED <b>10/9/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESTRELLITA O. K.</b>   |  |  |  | 22e. ADDRESS <b>LEVINTALE HEBREW GERIATRIC CENTER - HOSPITAL</b>               |  |   |  |

|  |  |                                |  |   |  |   |  |
|--|--|--------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>        |  | 23b. DATE <b>OCT. 12, 1980</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ADATH YESHURUN (BNAI JACOB LODGE)</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b> |  |
| 24 FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> |  |                                |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1980</b>                            |  | 25b. <b>10/14/80</b>  |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215                         |  |                                |  |   |  |   |  |

BP

CONFIDENTIAL

CONFIDENTIAL

1980

**NAME:** Bruce J. Schmidt

**DATE OF DEATH:** October 8, 1980

**PLACE OF DEATH:** Baltimore City

**SEE:** #80-25822  
Baltimore City

**DMH 2485 - Vit. Rec.**



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 2 5 8 1 5  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA Lillian Schraudner   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-18-80            |   |  | 2b. HOUR<br>4:45 P.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>07 26 99  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital  |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housekeeper |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS<br>Frogan Hill Nursing Center |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>FRANK Linnhart   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY FUKA |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no |  | 16b. SOCIAL SECURITY NO.<br>210-10-6271  |  | 17. INFORMANT<br>ADDRESS<br>5116 Shelbourne Rd.<br>LD Lillian Calender (dghtr)  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

1830  
(IMMEDIATE CAUSE (a)) SEPSIS AND RENAL FAILURE  
DUE TO, OR AS A CONSEQUENCE OF  
(b) CECAL PERFORATION  
DUE TO, OR AS A CONSEQUENCE OF  
(c) OVARIAN CARCINOMATOSIS

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>10/7/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Acute Abdomen      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/7/80 to 10/18/80, that (I) (we) last saw the deceased alive on 10/18/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>J. M. Williams MD  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>10/18/80   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. M. Williams MD   |  | 22e. ADDRESS<br>Mercy Hospital   |  |  |  |   |  |

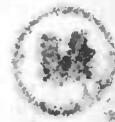
|  |  |                       |  |  |  |  |  |
|--|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial |  | 23b. DATE<br>10/22/80 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md. 21201 |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.   |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1980   |  | 25b. SIGNATURE<br>[Signature]                                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.



*Handwritten signature or initials.*

OCT 21 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 8 0 2 5 8 1 6<br>REG. NO.                             |  |  |  |
|--|--|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT)<br>CHARLES M. SCHULTZ SR.  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 9 80                               |  |  |  | 2b. HOUR<br>5 A M                                     |  |  |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7-20-42  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                |  |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hos |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Welder   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>General Electric |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALT.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>1522 SYCAMORE ST.              |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Michael ----- Schultz   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Josephine ----- Baburel   |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213-10-8231 A   |  | 17. INFORMANT<br>Mrs. Catherine J. Schultz, Same as above   |  |   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629 CARDIO-PULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE LUNG<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-23, 19 80, to 10-9, 19 80, that (I) (we) last saw the deceased alive on 10-9, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Sandra Lynn Howard   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>10/9/80  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Sandra Lynn Howard  |  |   |  | 22e. ADDRESS<br>3001 S. Hanover St.   |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Oct. 13, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>McClary Funeral Home, 4216 Pennington Ave. Balto. Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>F. J. H. H.  |  |   |  |  |  |



RELEASED AS NON MED BY DR SMITH OF THE



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |                          |   |   |  |                      | 8 0 2 5 8 1 7   |  |   |  |                                   |  |
|--|--|--|--|--|--------------------------|---|---|--|----------------------|-----------------|--|---|--|-----------------------------------|--|
| 1 - FOR STATE REGISTRAR  |  |  |  |  | REG. NO.                 |   |   |  |                      |                 |  |   |  |                                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH        |   |   | MONTH  |                      | DAY             |  | YEAR  |  | 2b. HOUR                          |  |
| HOWARD MERRILL SCHWARTZ  |  |  |  |  | OCTOBER 06, 1980         |   |   |  |                      |                 |  |   |  | 05:20PM                           |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                          | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | IF UNDER 1 YEAR  |                      | IF UNDER 24 HRS |  |   |  |                                   |  |
| MALE   |  | WHITE  |  | MARCH 17, 1917   |                          | 63  |   | MONTHS   |                      | DAYS            |  | HOURS   |  | MIN.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |                      |                 |  |   |  |                                   |  |
| MARYLAND   |  | U.S.A.   |  |  |                          | BALTIMORE CITY MD.  |   |  |                      |                 |  |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                          |   |   |  |                      |                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| BALTIMORE  |  | THE JOHNS HOPKINS HOSPITAL   |  |  |                          |   |   |  |                      |                 |  | PART OWNER  |  | C.R. + LOEBER                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  | 13b. CITY OR TOWN        |   | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS  |                 |  |   |  |                                   |  |
| MO. BALTO  |  |  |  |  | PARKVILLE                |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 2811 WILLOUGHBY ROAD |                 |  |   |  |                                   |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME |   |   |  |                      |                 |  |   |  |                                   |  |
| FIRST MIDDLE LAST  |  |  |  |  | FIRST MIDDLE LAST        |   |   |  |                      |                 |  |   |  |                                   |  |
| GEORGE E. SCHWARTZ   |  |  |  |  | MARY LOEBER              |   |   |  |                      |                 |  |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT ADDRESS   |  |                      |                 |  |   |  |                                   |  |
| NO   |  |  |  |  | 213 01 0654              |   | FAMILY RECORDS  |  |                      |                 |  |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                          |   |   |  |                      |                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |                                   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| IMMEDIATE CAUSE (a) Cardiogenic Shock  |  |  |  |  |                          |   |   |  |                      |                 |  | 1 hour  |  |                                   |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| (b) Probable Intra-operative Myocardial Infarction   |  |  |  |  |                          |   |   |  |                      |                 |  | 2 hours   |  |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| (c) Severe Coronary Artery Disease   |  |  |  |  |                          |   |   |  |                      |                 |  | Many Years  |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| Recent Acute Myocardial Infarction   |  |  |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |                          | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                      |                 |  |   |  |                                   |  |
| 10-6-80  |  | Occlusive Coronary Artery Disease  |  |  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                      |                 |  |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                          |   |   |  |                      |                 |  |   |  |                                   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
|  |  | P.M. 19  |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |                          | CITY OR TOWN  |   | COUNTY   |                      | STATE           |  |   |  |                                   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| 22a. I certify that (this hospital) attended the deceased from 10-6-80, to 10-6-80, that (we) lost saw the deceased alive on 10-6-80, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (didn't) view the body after death. |  |  |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| Roger E. Schneider   |  | MD   |  | 10-6-80  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| Roger E. Schneider MD  |  | Johns Hopkins Hospital   |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION   |   | CITY OR TOWN   |                      | COUNTY          |  | STATE   |  |                                   |  |
| BURIAL   |  | 10-9-1980  |  | GARDENS OF FAITH   |                          | BALTIMORE   |   |  |                      |                 |  | MARYLAND  |  |                                   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| NAME ADDRESS   |  | OCT 14 1980  |  | [Signature]  |                          |   |   |  |                      |                 |  |   |  |                                   |  |
| EVANS FUNERAL CHAPEL 8800 HARFORD ROAD   |  |  |  |  |                          |   |   |  |                      |                 |  |   |  |                                   |  |

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0024-1190

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 1 8

REG. NO.

|   |  |   |   |                                |   |
|---|--|---|---|--------------------------------|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | 2b. HOUR                       |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |   | 2b. HOUR                       |   |
| JOSEPHINE A. SCHWING  |  | 10 15 80  |   | 3:00 <sup>A</sup> <sub>M</sub> |   |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR                |   |
| Female  | Caucasian  | Mar. 17 <sup>th</sup> , 1914  | 66  | IF UNDER 24 HRS                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                |   |
| New York  | USA  |   | Baltimore City MD.  |                                |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                |   |
| Baltimore   | 2311 Ashland Ave.  | Clerk   | -   |                                |   |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS            |   |
| Maryland  | -  | Baltimore   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2311 Ashland Ave. 21205        |   |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |   |                                |   |
| Raymond J. Shour  | Frances - Rosslick   | No -  |   |                                |   |
| 16a. SOCIAL SECURITY NO.  | 17. INFORMANT  | ADDRESS   |   |                                |   |
| 215-10-86624  | Joseph Schwing, husband,   | same address  |   |                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <u>Acute myocardial infarction</u><br>410 -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b). <u>Interosseous cardiac vasculature</u><br>(c).<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |                                |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                |   |
|   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |                                |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |                                |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 78, to 19 80, that (I) (we) lost<br>saw the deceased alive on July 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |                                |   |
| 22b. SIGNATURE<br><u>Nicholas J. Fortuin</u>  | DEGREE<br>MD   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             | 22c. DATE SIGNED<br>10-16-80  |                                |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS   |   |   |                                |   |
| Nicholas Fortuin, M.D.  | 11 E. Chase St.  |   |   |                                |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |                                |   |
| Burial  | 10/18/80   | Most Holy Redeemer  | Baltimore Md.   |                                |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  | 25. REGISTRY<br>BY REGISTRY OR BY REGISTRY   | 25b. REGISTRY<br>BY REGISTRY OR BY REGISTRY   | 25c. REGISTRY<br>BY REGISTRY OR BY REGISTRY                         |                                |   |
| Schmunek Funeral Home, Inc.   | 331 Brehms Lane<br>Baltimore, Md. 21213  | OCT 21 1980   |   |                                |   |



*Handwritten signature or initials*

DEC 18 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 1 9

REG. NO.

|  |                  |   |                                |   |
|--|------------------|---|--------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOHN H. SCOTT   |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 5 80  |                                | 2b. HOUR<br>3:35 P.M.   |
| 3. SEX<br>MALE   | 4. RACE<br>BLACK | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 15, 08   |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>CAMDEN, N.J.  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |                  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>KIMBLE & TYLER  |                                | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL                 |                                | 13a. STREET ADDRESS<br>2817 BRIGATON ST.  |
| 13a. STATE<br>MARYLAND   |                  | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTIMORE | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN H. SCOTT  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SUSAN  |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO.  |                  | 16b. SOCIAL SECURITY NO.<br>215-01-2527   |                                | 17. INFORMANT (WIFE)<br>OPHELIA SCOTT   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) metastatic oat cell ca of the lung<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                  |   |                                |   |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |                                |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                  | 22a. ADDRESS<br>Johns Hopkins Hospital  |                                |   |
| 22b. SIGNATURE<br>R. McLaughlin MD   |                  | DEGREE<br>MD  |                                | 22c. DATE SIGNED<br>10/5/80   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. MCGLAUGHLIN  |                  | 22e. ADDRESS<br>Johns Hopkins Hospital  |                                |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |                  | 23b. DATE<br>10-8-80  |                                | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM. PARK ARBUTUS, MARYLAND   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>LEROY O. DYETT & SON 4600 L.B. HIGGS AV.  |                                |   |
| 25a. DATE REC'D. BY REGISTRAR<br>OCT 8 1980  |                  | 25b. REGISTRAR'S SIGNATURE<br>Anthony McQuerry  |                                |   |

MEDICAL CERTIFICATION

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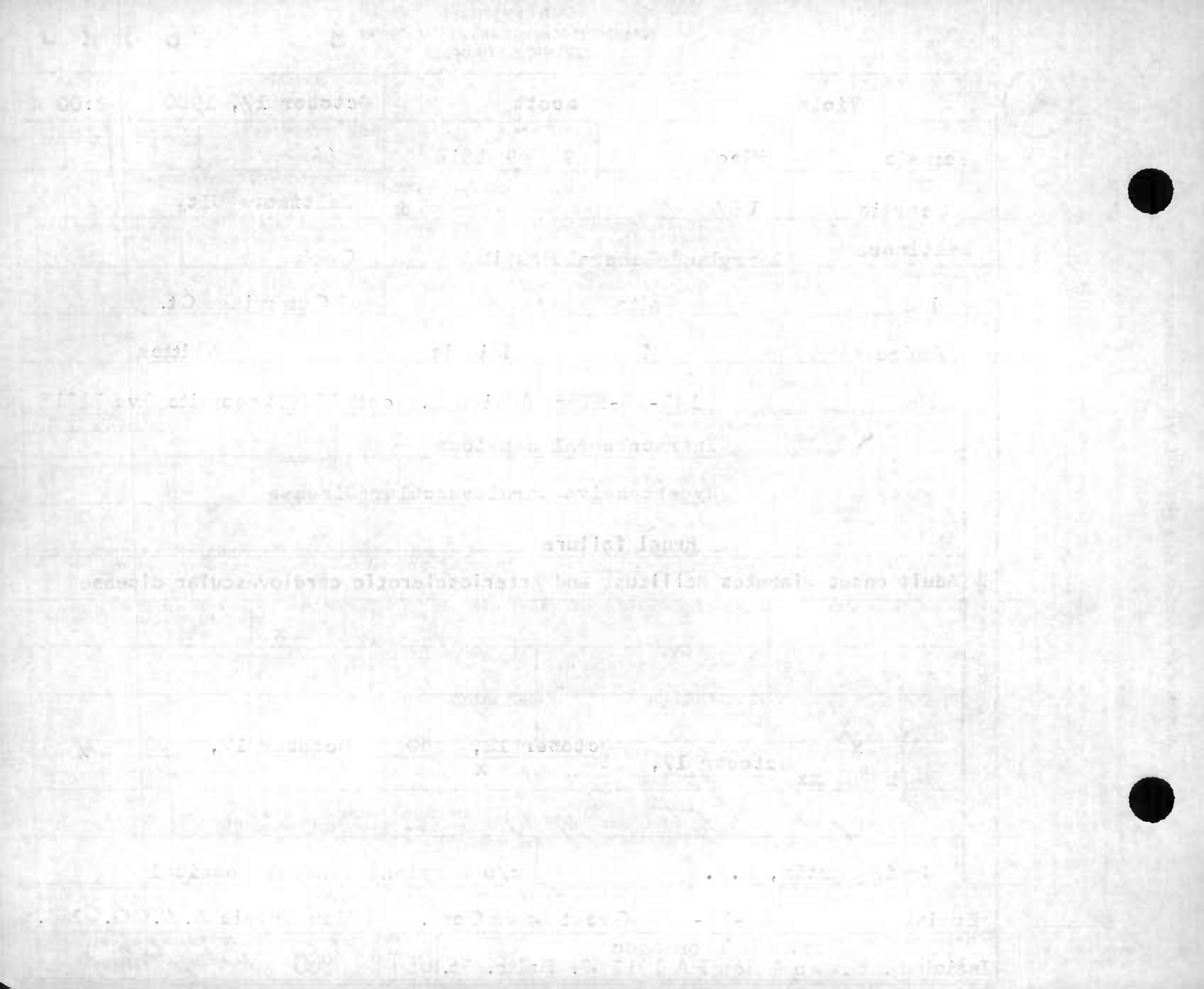
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 2 5 8 2 0  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| Viola Scott  |  |  |  | October 17, 1980   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| Female   |  | Black  |  | 9 MONTH 9 DAY 1914 YEAR  |  | 66 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| Georgia  |  | USA  |  |  |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Baltimore  |  | Maryland General Hospital  |  | Cook   |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  |
| Md   |  |  |  |  |  | Balto  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| Andrew   |  |  |  | Minnie Whitten   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| No   |  |  |  | 142-18-5755  |  | Adrian B. Scott 3249 Yosemite Ave 21215                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Intracerebral Hematoma   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease   |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |
| Adult onset Diabetes Mellitus, and Arteriosclerotic cardiovascular disease   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
|  |  |  |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from October 12, 1980 to October 17, 1980, that (we) lost saw the deceased alive on October 17, 1980, and that in (we) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Craig Martin M.D.  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 10-17-80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| Craig Martin, M.D.   |  |  |  | c/o Maryland General Hospital  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial   |  | 10-21-80   |  | Crest Lawn Cem.  |  | Glen Burnie A.A.CO. Md.  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Brown & Thompson   |  |  |  | OCT 21 1980  |  | Isaiah L. Brown & Son PA 1913 W. Balto. St.                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 2 1  
REG. NO.

|  |  |  |  |   |  |   |   |   |  |
|--|--|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN</b> <b>Schlee</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 25, 1980</b>         |   |  | 2b. HOUR<br><b>5:30 PM</b>  |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 6, 1987</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>5 12 30</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Caton Manor Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Engraver</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Photography</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Catonsville</b>                              |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Schlee Sr.</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Bauersox</b>  |   |  | 13e. STREET ADDRESS<br><b>107 Fairfield Dr. 21228</b>                               |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW I 215-10-7953</b>                    |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Molly A. Schlee Same as # 13</b> |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>A.S.C.V.D.</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC RENAL FAILURE</b>                      |  |  |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>17 YRS</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>CHRONIC RENAL FAILURE</b>  |  |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-21-1980</b> to <b>10-25-1980</b> , that (I) (we) last saw the deceased alive on <b>10-14-1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Baskaran</b>  |  |  |  |   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>10-26-80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMBANDAM BASKARAN</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>1900 SULPHUR SPRING RD<br/>BALTIMORE, MD 21227</b>               |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>10/30/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balt. Md.</b>                         |   |  |
| 24. FUNERAL DIRECTOR<br><b>MacNabb Funeral Home</b>  |  |  |  |   |  | ADDRESS<br><b>Catonsville, Md.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 3 1980</b>  |  |



CHRONIC KIDNEY FAILURE

10 - 4 - 50

10 - 4 - 50

10 - 4 - 50

10 - 4 - 50

10 - 4 - 50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 8 0 2 5 8 2 2   |  |  |  |   |  |  |  |   |  |
| REG. NO.  |  |  |  |   |  |  |  |   |  |
| 1. FOR STATE REGISTRAR<br>DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>BRUCE J. SCHMIDT   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 8 80  |  | 2b. HOUR<br>1:50 AM   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 4 66   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>14 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GOOD SAMARITAN HOSP. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |   |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>PARKVILLE  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>7908 DALESFORD ROAD  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>FRZD W. SCHMIDT III  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARTHA J. ROSIER  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>215 94 6492  |  | 17. INFORMANT ADDRESS<br>FAMILY RECORDS   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ELECTRO MECHANICAL DISSOCIATION</u><br>3941 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>VENTRICULAR ARRHYTHMIA</u><br>(c) <u>MITRAL REGURGITATION - RHEUMATIC FEVER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  |  |  |   |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 HOURS   |  |  |  |   |  |  |  |   |  |
| MEDICAL CERTIFICATION   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (we) (this hospital) attended the deceased from 10/8/80 to 10/8/80, that (we) lost saw the deceased alive on 10/8/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>S. K. NAIR MD   |  |  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |  |  |  | 22c. DATE SIGNED<br>10/8/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. K. NAIR   |  |  |  | 22e. ADDRESS<br>GOOD SAMARITAN HOSPITAL   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>10-11-1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. P. PARKVILLE  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>EVANS FUNERAL CHAPEL   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

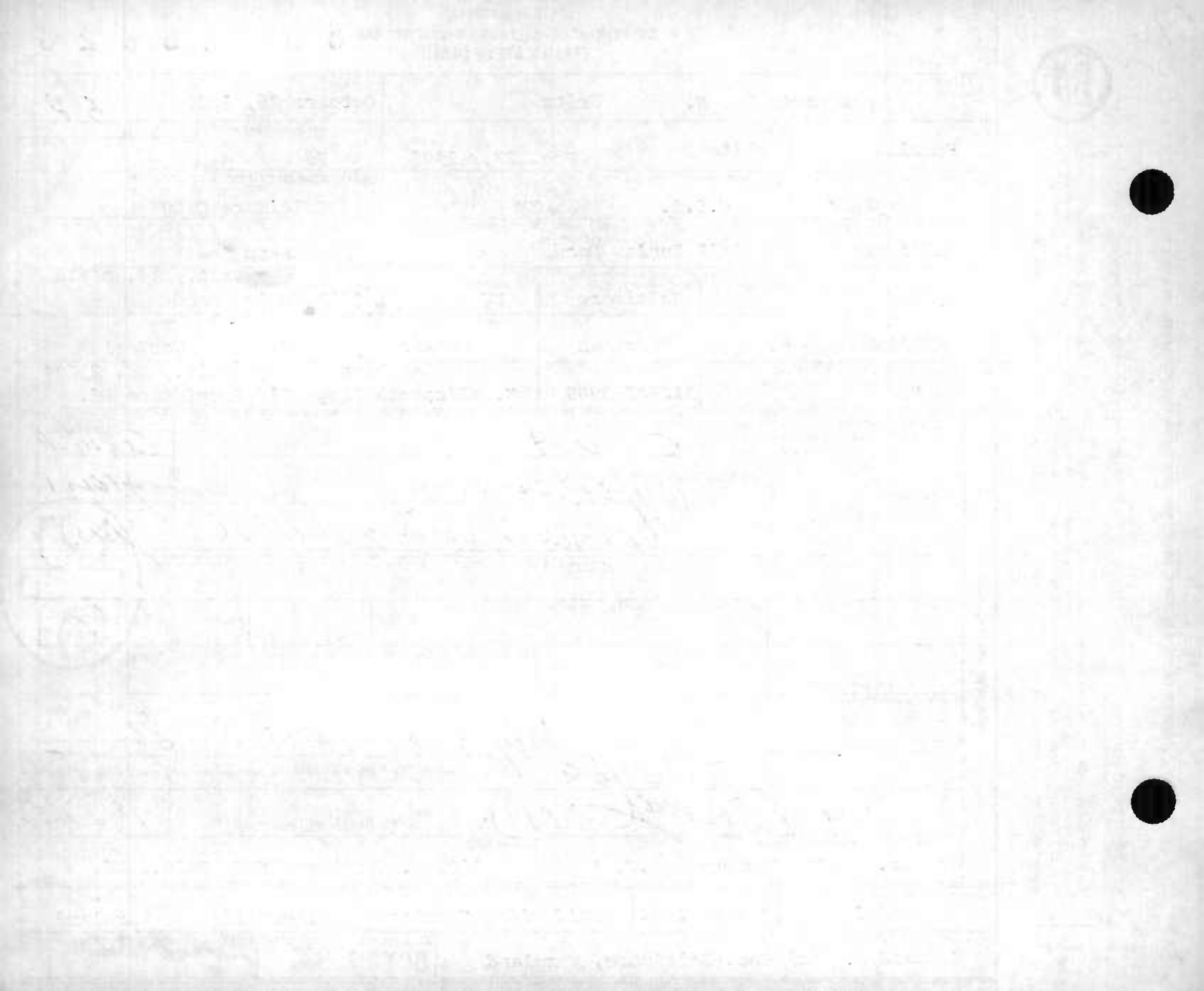
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

OHMH-16 30M 2/80  
(VRA 15, 4)



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 5 8 2 3   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Margaret H. Seitz</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>October 25, 1980</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 27, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1517 Tunlaw Road</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William W. Harryman</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie L. MacNeal</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-22-5989</b>  |  | 17. INFORMANT <b>Daughter:</b> ADDRESS <b>Balt., Md. 21204</b><br><b>M. Elizabeth Frey 814 Providence Rd.</b>                        |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C. U. A</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b> |  |  |  | V<br><b>Recent</b><br><b>years</b><br><b>years</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>July 13, 1968 to Oct. 8, 1980</b>   |  |  |  |
| 22a. I certify that (I) (we) attended the deceased from above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Carlos Aranaga M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>10/27/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Carlos Aranaga M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>1900 E. Northern PKWY Balt., Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>Oct 28 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Brady</b>   |  |

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 2 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |  |
|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Adam Setlak  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 25, 1980   |  | 2b. HOUR<br>M  |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>February 15, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73<br>YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1628 Lancaster St.                      |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor       | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bag Co.   |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Setlak   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eva Kalinowski   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-01-6503  |  | 17. INFORMANT<br>ADDRESS<br>Evelyn Ravita, 3547, Baltimore, Maryland   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of Pancreas</u><br>1579<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>+ 2 mos |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>None   |  |   |  |  |
| 19a. DATE OF OPERATION<br>None  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/80</u> , 19____, to <u>10/25/80</u> , 19____, that (I) (we) last saw the deceased alive on <u>10/25/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |
| 22b. SIGNATURE<br>Bernardo John Yukna MD  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>27 OCT 81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BERNARDO JOHN YUKNA, MD  | 22e. ADDRESS<br>404 BOWLEY'S CIR RD BALTO, MD 21206  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>Oct. 28, '80  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Rosary Cemetery  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lilly & Zeiler, Inc. 1901 Eastern Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1980  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

*[Faint bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 2 5  
REG. NO.

|   |                         |   |  |   |  |  |  |
|---|-------------------------|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |                         | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SEWELL, EDWIN J.</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-8-80</b>   |  | 2b. HOUR<br><b>11:10</b> <sup>M</sup>  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH <b>2-8-03</b><br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, Md.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3900 LOCH RAVEN BLVD. V.A. Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |                         | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William - Sewell</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Cosgrove</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WWII</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-5100</b>   |  |
| 17. INFORMANT<br><b>Calvert Sewell, son,</b>  |                         | 17a. ADDRESS<br><b>1518 Dellsway Rd.</b>  |  | 17b. CITY OR TOWN<br><b>21204</b>   |  | 17c. STATE<br><b>-</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>6 weeks</b><br><b>- weeks -</b> |                         |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>History of apparent carcinoma of the lung - not biopsy proven</b>  |                         |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>none</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>NONE</b>  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21g. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>8-28</b> , 19 <b>80</b> , to <b>10-8</b> , 19 <b>80</b> , that (we) lost<br>saw the deceased alive on <b>10-8</b> , 19 <b>80</b> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (a) (we) (did) (not) view the body after death.   |                         |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Arthur J. Lomant</b>   |                         | 22c. ADDRESS<br><b>22 S. Greene St. Baltimore VAME</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur J. Lomant</b>  |  | 22e. ADDRESS<br><b>22 S. Greene St. Baltimore VAME</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>10/11/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.,</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Schumnek Funeral Home, Inc.</b>  |                         | 24b. ADDRESS<br><b>3331 Brehms Lane</b>   |  | 24c. CITY OR TOWN<br><b>Baltimore, Md.</b>  |  | 24d. STATE<br><b>21213</b>   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1980</b>   |                         | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Lomant</b>   |  | 25c. REGISTRAR'S SIGNATURE<br><b>L. J. Lomant</b>   |  |  |  |

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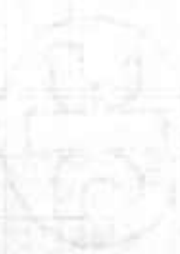
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 5 8 2 6   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Agnes S Shannahan</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 14 80</b>  |  | 2b. HOUR<br><b>11 56</b> M   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 01 92</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Delaware</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Thomas Francis Eaton</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Lang</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-70-2056</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Thomas O. Shannahan, Sr. 1228 Landover</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory arrest</u><br><b>2396</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>brain tumor</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months +</b> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-21</u> , 19 <u>80</u> , to <u>10-14</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10-14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Richard A. Brown MD</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>14 October 1980</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD NORA</b>   |  |   |  | 22e. ADDRESS<br><b>5601 Loch Raven Blvd.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/17/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Parkville Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LISSAHN F.X. - 7401 BELAIR Rd</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Oct 20 1980</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |   |  | 80  | 25827 |
|---|--|---|--|---|--|--|---|---|--|---|-------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |   |   |  |   |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Madeline C. Shank   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 23 1980   |   |   | 2b. HOUR<br>11 M   |   |       |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug 10 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |   |  |   |       |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>327 S. Macon St. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machine Operator   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lever Bros.   |   |       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>Md.   |  |   |  |   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br>Balto.                       |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Nagengast  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Caroline Engle  |   |   |  |   |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |   |  | 16b. SOCIAL SECURITY NO.<br>215-05-4117   |  | 17. INFORMANT<br>Marjorie Sibold (niece) AVE.  |   |   | ADDRESS 2200 Mayfield  |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Decompensation<br>496-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>Chronic Obstructive Airway Disease 12 yrs.<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10a.<br>Probable Bronchogenic Carcinoma |  |   |  |   |  |  |   |   |  |   |       |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |       |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 19 57, to Oct. 19 80, that (I) (we) last saw the deceased alive on Sept. 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |   |  |   |       |
| 22b. SIGNATURE<br>Clarence W. LeDoux MD   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>10/24/80   |   |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Clarence W. LeDoux   |  |   |  |   |  | 22e. ADDRESS<br>3023 Eastern Ave.  |   |   |  |   |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>10/25/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Jesus Balto. |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Md. |  |   |       |
| 24. FUNERAL HOME<br>Schlunke Funeral Home, Inc.   |  |   |  |   |  | 3331 Brehms Lane<br>Balto. Md. 21213   |   | 25a. DATE REC'D. BY REGISTRAR<br>Oct. 24 1980     |  | 25b. REGISTRAR'S SIGNATURE<br>Fitzpatrick   |       |

THE UNIVERSITY OF CHICAGO  
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TO THE STONE ORGANIC CHEMISTRY

(1-11-1961) (101)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 5 8 2 8   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ETHEL F. SHARP</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10/12/1980</b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>05/05/1892</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>88</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hosp.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Buyer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hecht Dept. Store</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><b>Md. A.A. Glen Burnie</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1220 Kimberly Lane</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Page</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Weber</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 097548</b>  |  | 17. INFORMANT ADDRESS<br><b>Ronald Stoll same as 13 e</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>- CARDIO-PULMONARY ARREST</b><br>4280<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>- RESPIRATORY INSUFFICIENCY</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Now</b><br><b>DAYS to</b><br><b>Months</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>—</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b>—</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>09/20/1980</b> to <b>10/12/1980</b> , that (I) (we) lost saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>J.R. Angil</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10/12/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANJARIA MD</b>  |  |  |  | 22e. ADDRESS<br><b>NORTH CHARLES HOSPITAL BALTIMORE MD 21218</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/14/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>George J. Gonce</b>   |  |  |  | ADDRESS<br><b>4001 Ritchie Hwy. Balto 21225</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1980</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Ruby M. Kelly</b>  |  |  |  |

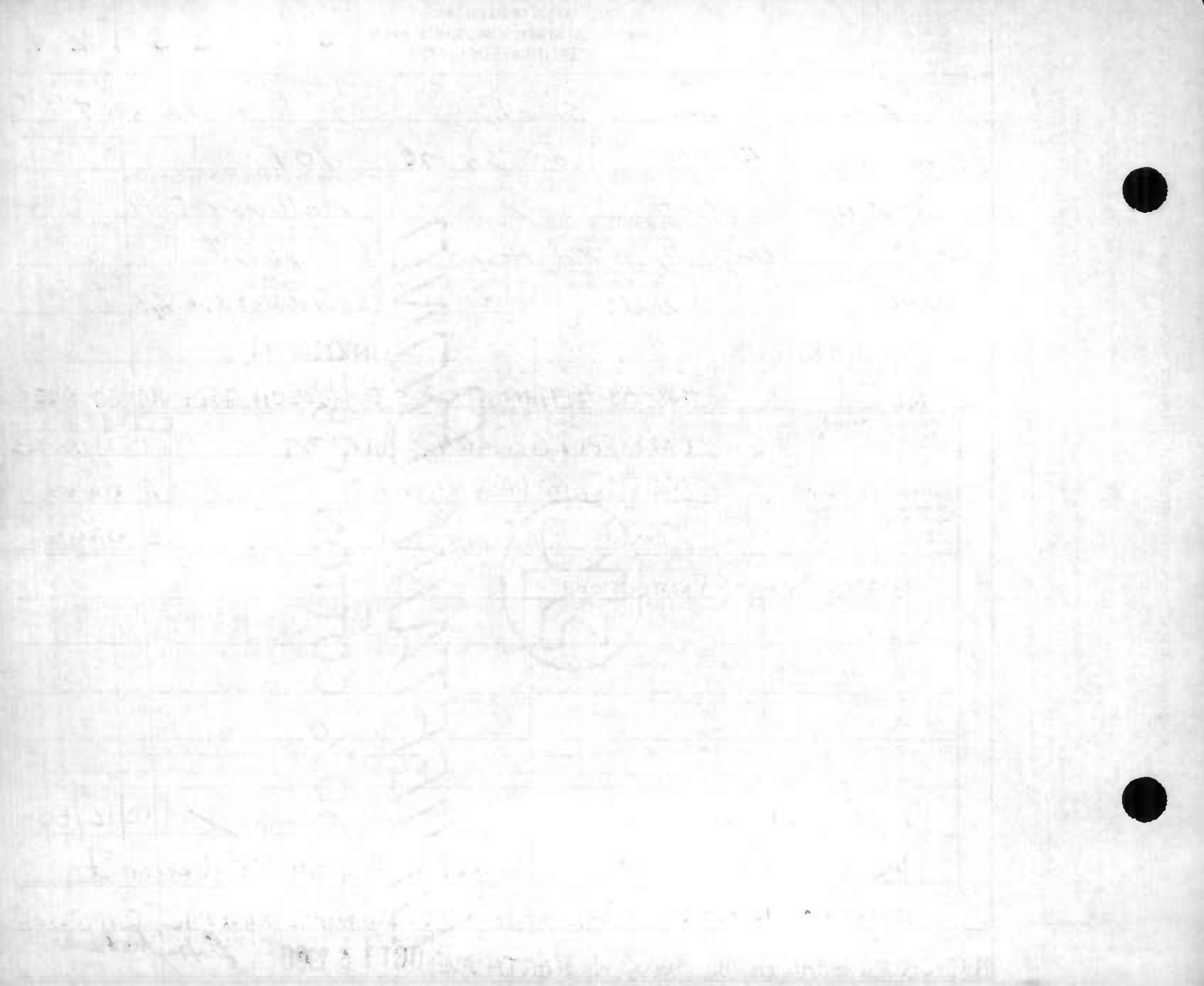


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  | 70 0 2 5 8 2 9   |  |
|--|--|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Evva NMI Sharp</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 12 80</i>  |  |  | 2b. HOUR<br>P<br><i>7 10</i>   |  |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Black</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>07 25 76</i>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>104</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Georgia</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balt</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University of Md. Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Unemployed</i>           |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |  |
| 13a. STATE<br><i>md</i>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><i>Balt</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>2501 Violet Ave. Apt</i>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>UNKNOWN</i>                                 |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>408-38-4947</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>MRS FRANCES E. HUDSON 2501 VIOLET AVE</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i><br><i>5609</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>PNEUMONIA (ASPIRATION)</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <i>Lower OBSTRUCTION</i> |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>15 MINUTES</i><br><i>2 DAYS</i><br><i>2 DAYS</i>                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><i>URINARY TRACT INFECTION</i>   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><i>NONE</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (and) (did not) view the body after death.  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>David S. Prince md</i>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>10/12/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>DAVID S. PRINCE MD</i>   |  |   |   | 22e. ADDRESS<br><i>UNIVERSITY HOSPITAL 225 GREENE ST</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>10-17-80</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>OAKLAND CEMETERY</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>RURAL KNOXVILLE TENNESSEE</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>NUTTER FUNERAL HOME 3035 W. NORTH AVE</i>   |  |   |   | ADDRESS<br><i>3035 W. NORTH AVE</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 16 1980</i>  |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |



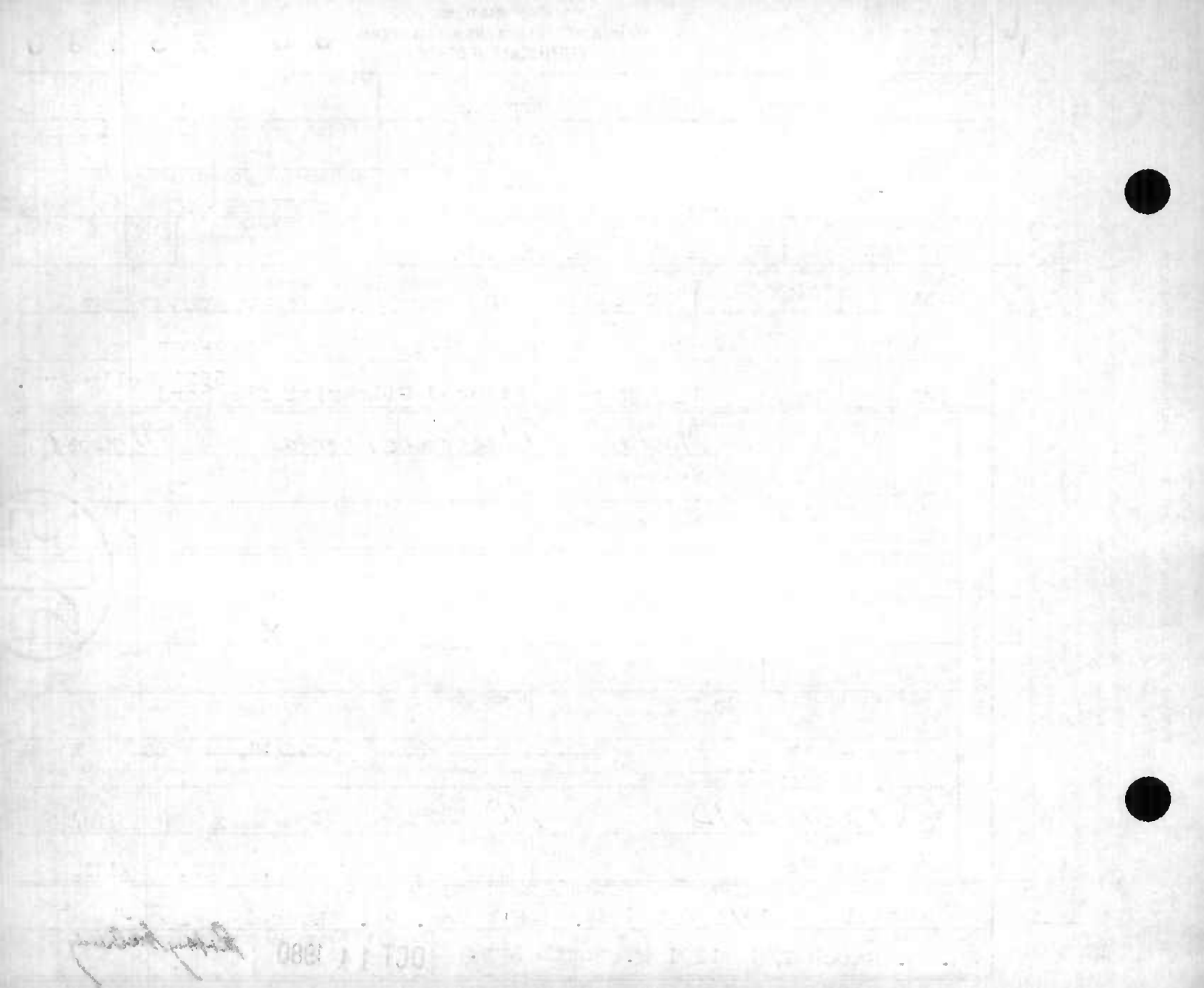
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |                     |
|---|--|--|--|---|--|---|--|--|--|---------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WALTER ELEY SHEPHERD   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 10 80                |   |  |  |  | 2b. HOUR<br>1:55P M |
| 3. SEX<br>MALE  |  | 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 15 30   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                       |  |  |  |                     |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VA MEDICAL CENTER BALTO.MD. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                     |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5629 BELLE AVENUE 21207   |  |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WALTER SHEPHERD   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY LAWRENCE |   |  |  |  |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>KOREAN  |  | 17. INFORMANT<br>ADDRESS<br>5629 Belle Ave.<br>Mildred Gilchrist Shepherd   |  |   |  |  |  |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Mucinous Adenocarcinoma</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 months   |  |  |  |   |  |   |  |  |  |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |                     |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                     |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>OCT. 9,</u> 19 <u>80</u> , to <u>OCT. 10,</u> 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>OCT. 10,</u> 19 <u>80</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not view the body after death.) |  |  |  |   |  |   |  |  |  |                     |
| 22b. SIGNATURE<br><u>K. Raines MD</u>   |  |  |  |   | DEGREE<br><u>MD</u>  |   |  | 22c. DATE SIGNED<br>10/10/80   |  |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>K. Raines</u>   |  |  |  |   | 22e. ADDRESS<br>3900 LOCH RAVEN BLVD. BALTO.MD. 21218          |   |  |  |  |                     |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/15/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat'l Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel MD   |  |  |  |                     |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980                   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |  |  |                     |



20

*[Handwritten signature]*

0801 11 100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

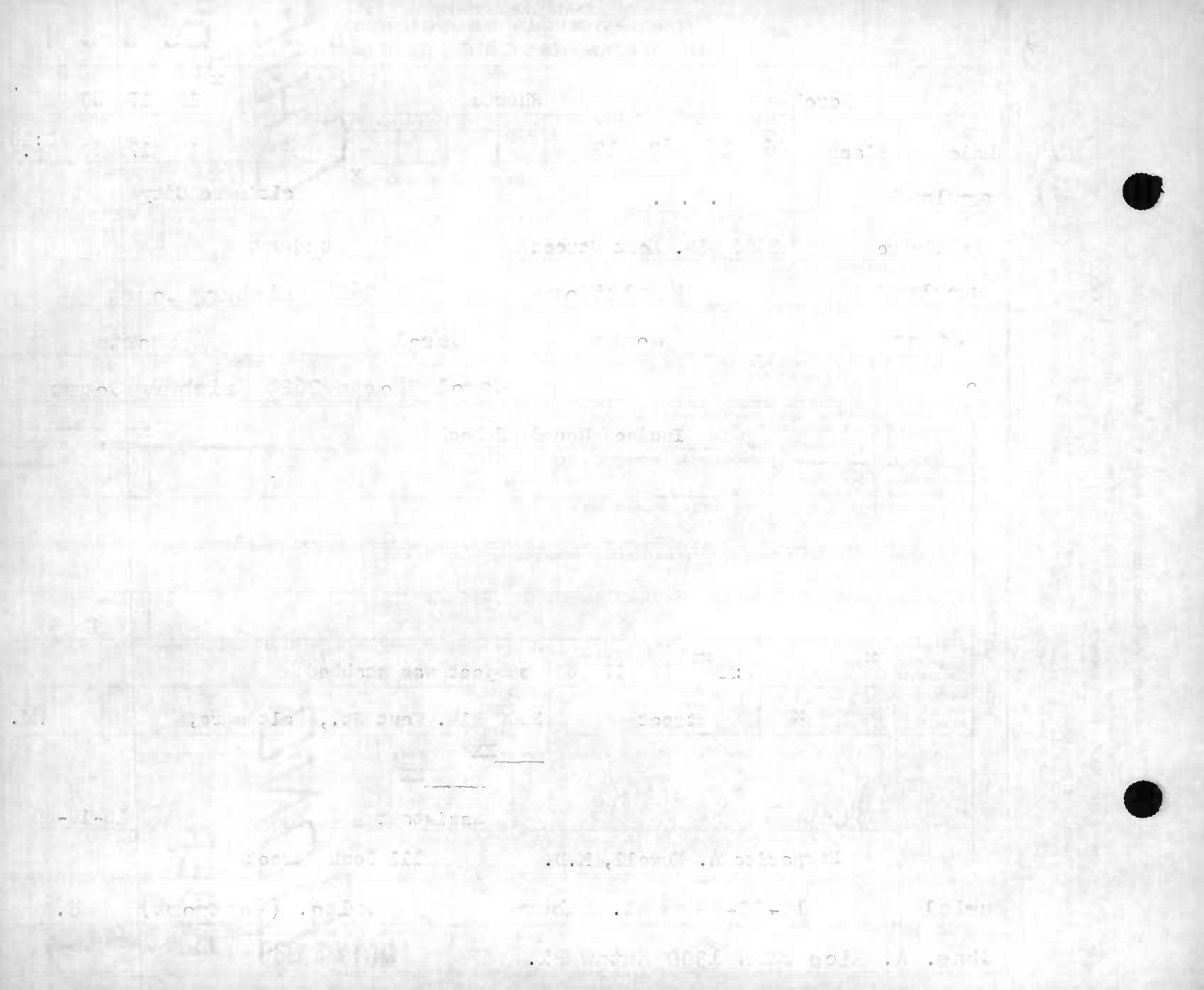
REG. NO. 0 2 5 8 3 1

|  |  |                         |  |  |  |   |  |   |  |                                |  |   |  |   |  |   |  |     |  |                           |  |
|--|--|-------------------------|--|--|--|---|--|---|--|--------------------------------|--|---|--|---|--|---|--|-----|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Derek</b>  |  |                         |  | FIRST  |  |   |  | MIDDLE  |  |                                |  | LAST<br><b>Shorts</b>   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 17 1980</b> |  |     |  | 2b. HOUR<br>M <b>8:18</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 16 63</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>17</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>10 17 1980</b>                                    |  |   |  | 2d. HOUR<br>P.M. <b>8:18</b>  |  |     |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                   |  |   |  |   |  | MD. |  |                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2600 Blk. Kent Street</b> |  |   |  |   |  |                                |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                 |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |     |  |                           |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  | 13e. STREET ADDRESS<br><b>2624 Maisburg Court</b>   |  |     |  |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Jones</b>   |  |                         |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carol Shorts</b>  |  |                                |  |   |  |   |  |   |  |     |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT ADDRESS<br><b>Carol Shorts 2624 Maisburg Court</b>  |  |                                |  |   |  |   |  |   |  |     |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Incised Wound of Neck</b><br><b>966-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                         |  |  |  |   |  |   |  |                                |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |     |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |                         |  |  |  |   |  |   |  |                                |  |   |  |   |  |   |  |     |  |                           |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                                |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |     |  |                           |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR <b>7:55</b> P.M. MONTH DAY YEAR <b>10 17 1980</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject was stabbed</b>   |  |                                |  |   |  |   |  |   |  |     |  |                           |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2600 Blk. Kent St., Baltimore, Md.</b>  |  |                                |  |   |  |   |  |   |  |     |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |  |                                |  |   |  |   |  |   |  |     |  |                           |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |                         |  | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |  | DATE SIGNED<br><b>10-18-80</b>  |  |                                |  | M.D. MEDICAL EXAMINER   |  |   |  |   |  |     |  |                           |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  |                         |  | ADDRESS<br><b>111 Penn Street</b>  |  |   |  |   |  |                                |  |   |  |   |  |   |  |     |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>10-22-80</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>   |  |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. (Westport) Md.</b>                      |  |   |  |   |  |     |  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Chas. A. Rice FSPA 1300 Eutaw Pl.</b>   |  |                         |  |  |  |   |  |   |  |                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Richard M. Brady</i>                               |  |   |  |     |  |                           |  |

BP

DHMH - 17  
TVR A15 ME (51)  
15M 7/76

2543

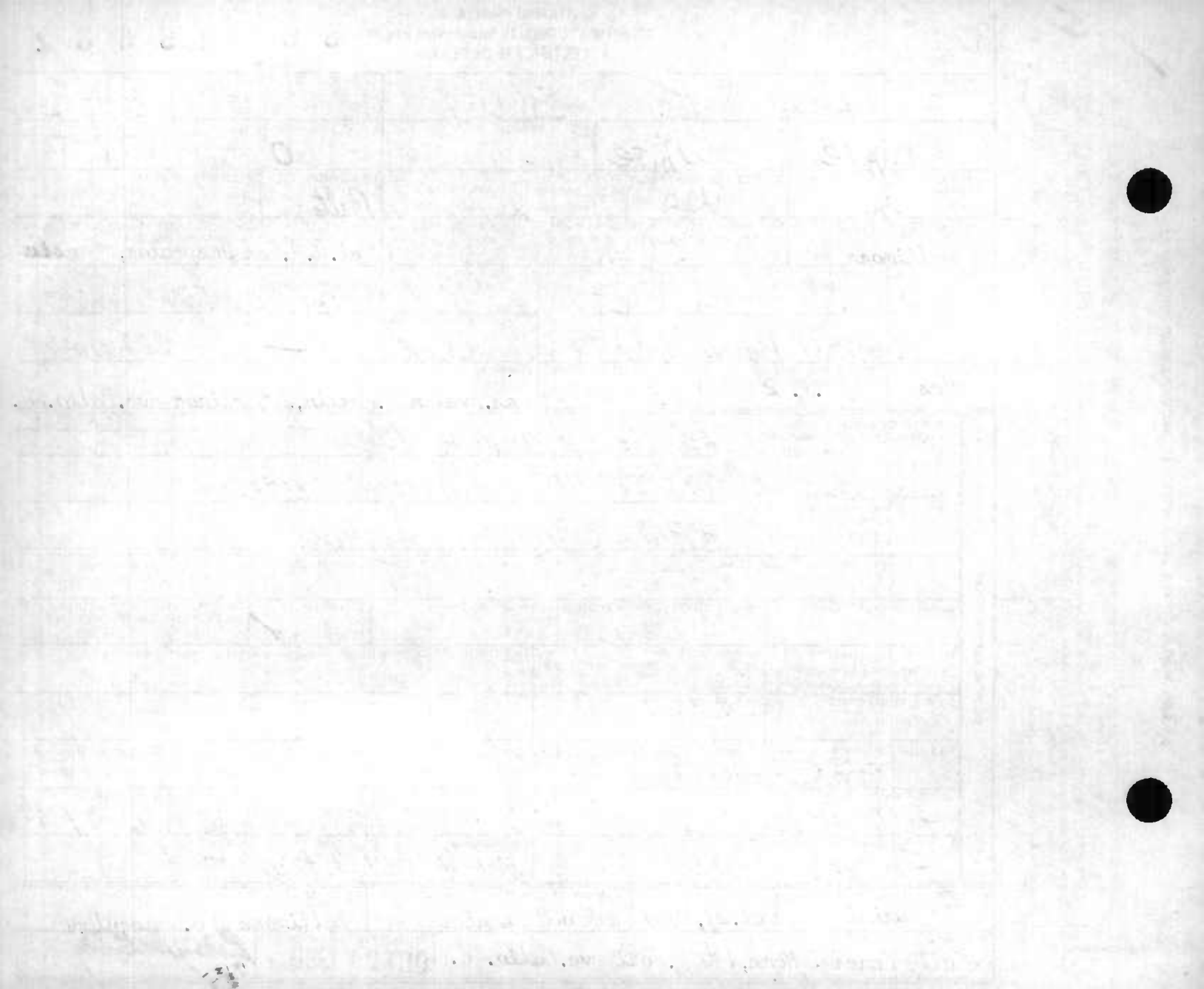


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  | 80 |  | 25832 |  |
|--|--|--|--|---|---|--|--|--|--|----|--|-------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |   |  |  |  |  |    |  |       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>AMOS E. SIBLEY   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 19 80   |  | 2b. HOUR<br>12 42 M                    |  |  |    |  |       |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-12-19  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |    |  |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. CITY MD.   |  |  |  |    |  |       |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SBGH                    |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. R.R. (car Inspector, Chesapeake |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |    |  |       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>31 E. FORT AVE. |  |  |    |  |       |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.   |   |  |  |  |  |    |  |       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>EDWARD Barnes SIBLEY   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>OLIVE RAINIER                                  |  |  |  |  |    |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(YEAR OF BIRTH OR DATES)<br>W.W. 2<br>218-14-7514  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Evelyn E. Martin, 209 Elinora Ave. Balto. Md.  |   |  |  |  |  |    |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac pulmonary arrest<br>486-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Death MI, hypoxemia, acidosis<br>(c) Extensive pneumonia, possible sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |   |  |  |  |  |    |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |  |  |  |  |    |  |       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |    |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |    |  |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |    |  |       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/19/80 to 10/19/80, that I (we) last saw the deceased alive on 10/19/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |  |    |  |       |  |
| 22b. SIGNATURE<br>A. Crowley M.D.  |  | 22c. DATE SIGNED<br>10-19-80   |  |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HANSER Cowley   |  |  |  |    |  |       |  |
| 22e. ADDRESS<br>South Balto. Gen Hosp.   |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |   |  |  |  |  |    |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Oct. 23, 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. Maryland                                     |  |  |  |    |  |       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Dorothy M. [Signature]  |   |  |  |  |  |    |  |       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in one of the following ways:

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 8025833 |  |
|---|--|---|--|---|--|--|--|---|--|------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  |                  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Etta M. Sickel</i>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>October 19, 1980</i>      |  |  | 2b. HOUR<br>M   |  |                  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>August 15, 1981</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><i>99</i>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>City</i> MD.                                      |  |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>2820 Alvarado Square</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                  |  |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>2820 Alvarado Square</i>  |  |                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Charles Albert Knauff</i>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Agnes Nicol</i> |  |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>217-14-1187D</i>   |  | 17. INFORMANT ADDRESS<br><i>Mrs. Leona S. Watts same</i>  |  |  |  |   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><i>5314</i> IMMEDIATE CAUSE (a) <i>C.I. Bleeding - Anemia</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ulcer</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |   |  |   |  |  |  |   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/18</i> 19 <i>80</i> , to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |                  |  |
| 22b. SIGNATURE<br><i>Celilar Parra</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |  |  | 22c. DATE SIGNED  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Celilar Parra MD</i>  |  |   |  | 22e. ADDRESS<br><i>7122 Harford Rd. Baltimore, Maryland</i>   |  |  |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>Oct. 22, 1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Woodlawn</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore Balto. Md.</i>                       |  |   |  |                  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Leonard J. Ruck Inc.</i>  |  |   |  | ADDRESS<br><i>Baltimore, Maryland</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 20 1980</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Rickey McCreedy</i>  |  |                  |  |



of the - Answer  
1907

1907  
Answer

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |                  |   |                          |   |                     | REG. NO. 25834 |      |  |          |
|--|---------|--|--|---|------------------|---|--------------------------|---|---------------------|----------------|------|--|----------|
| 1. FOR STATE REGISTRAR   |         | DECEASED NAME (TYPE OR PRINT)                            |  | FIRST   | MIDDLE           | LAST  | 2a. DATE OF DEATH        |   | DATE KNOWN OF DEATH | MONTH          | DAY  | YEAR   | 2b. HOUR |
|  |         | Harry  |  |   |                  | Silver  | 10                       |   | 10                  | 8              | 19   | 80   |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   | IF UNDER 24 HRS. |   | 7c. DATE PRONOUNCED DEAD |   | MONTH               | DAY            | YEAR | 2d. HOUR                                     |          |
| Male   | White   | MAY 30, 1906   |  | 74 YRS.   |                  |   | 10                       |   | 8                   | 19             | 80   | 12:15 A.M.                                   |          |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                          |   |                     |                |      |  |          |
| MARYLAND   |         | USA  |  | XX  |                  | Baltimore City, MD.   |                          |   |                     |                |      |  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                          |   |                     |                |      |  |          |
| Baltimore  |         | University Hospital                                      |  | ATTORNEY  |                  | AT LAW  |                          |   |                     |                |      |  |          |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                  | 13d. INSIDE CITY LIMITS?  |                          | 13e. STREET ADDRESS   |                     |                |      |  |          |
| MARYLAND   |         | BALTO.   |  | BALTIMORE   |                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          | 3600 PHILLIPS DR.   |                     | #21208         |      |  |          |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |  | 16a. SOCIAL SECURITY NO.                                      |                  | 17. INFORMANT   |                          |   |                     |                |      |  |          |
| HYMAN  |         | SILVER   |  | DENA  |                  | MRS. ADA S. SILVER  |                          |   |                     |                |      |  |          |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16c. SOCIAL SECURITY NO.                                 |  | 17. INFORMANT   |                  | ADDRESS   |                          |   |                     |                |      |  |          |
| NO   |         | 217-12-8315  |  | 3600 PHILLIPS DR.   |                  | BALTO., MD  |                          | 21208   |                     |                |      |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |   |                  |   |                          |   |                     |                |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART I DEATH WAS CAUSED BY:  |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| IMMEDIATE CAUSE (a) 8147 Complications of blunt injury to trunk  |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| (b)  |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| (c)  |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |                  |   |                          | 20. AUTOPSY?  |                     |                |      |  |          |
|  |         |  |  |   |                  |   |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |                     |                |      |  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY   |                  |   |                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                     |                |      |  |          |
|  |         |  |  | 7:35 AM, 3 7 19 80  |                  |   |                          | Pedestrian struck by truck  |                     |                |      |  |          |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                  |   |                          | 21f. LOCATION   |                     |                |      |  |          |
|  |         |  |  | street  |                  |   |                          | Rt. 140 Pikesville, Baltimore, Md.  |                     |                |      |  |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |  |   |                  |   |                          |   |                     |                |      |  |          |
| ACTUAL SIGNATURE   |         |  |  | TITLE (SPECIFY)   |                  |   |                          | DATE SIGNED   |                     |                |      |  |          |
| Virginia L. Dolan  |         |  |  | Assistant   |                  |   |                          | 10/8/80   |                     |                |      |  |          |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |  |  | ADDRESS   |                  |   |                          |   |                     |                |      |  |          |
| Virginia L. Dolan, M.D.  |         |  |  | 111 Penn Street   |                  |   |                          |   |                     |                |      |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |  |  | 23b. DATE   |                  |   |                          | 23c. NAME OF CEMETERY OR CREMATORY  |                     |                |      |  |          |
| BURIAL   |         |  |  | OCT. 9, 1980  |                  |   |                          | CHIZUK AMINO  |                     |                |      |  |          |
| 24. FUNERAL DIRECTOR NAME  |         |  |  | 25a. DATE REC'D. BY REGISTRAR                                 |                  |   |                          | 25b. REGISTRAR'S SIGNATURE  |                     |                |      |  |          |
| SOL LEVINSON & BROS., INC.   |         |  |  | OCT 14 1980   |                  |   |                          | [Signature]   |                     |                |      |  |          |
| 6010 REISTERSTOWN RD.  |         |  |  | BALTO., MD  |                  |   |                          | 21215   |                     |                |      |  |          |



OFFICE OF THE SECRETARY

WASHINGTON, D.C.

Department of the Interior

Division of Reclamation

Water Conservation Division

Division of Reclamation

Division of Reclamation

Division of Reclamation

*[Handwritten signature]*

1901

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |  |        |   |                            |  |                  |   |                                      |  |          |
|--|---------|--|--------|---|----------------------------|--|------------------|---|--------------------------------------|--|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  | MIDDLE | LAST  | 2a. DATE KNOWN<br>OF DEATH |  | ESTI-<br>MATED   | MONTH   | DAY                                  | YEAR   | 2b. HOUR |
| Nicola Silvestri   |         |  |        |   | xx 10 19 80                |  |                  |   |                                      |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (IN YEARS)   | IF UNDER 1 YR.             |  | IF UNDER 24 HRS. |   | 7c. DATE<br>PRONOUNCED<br>DEAD       |  | 2d. HOUR |
| male   | white   | Nov. 5, 1903   |        | 76 YRS.   |                            |  |                  |   | 10 20 19 80                          |  | 11:08    |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |                  |   |                                      |  |          |
| Italy  |         | USA  |        |   |                            | Baltimore City   |                  |   |                                      |  |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |   |                            | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) |                  |   | 12b. KIND OF BUSINESS<br>OR INDUSTRY |  |          |
| Baltimore  |         | 31 N. Luzerne Avenue   |        |   |                            | Machinist  |                  |   | -                                    |  |          |
| 13a. STATE   |         |  |        |   |                            |  |                  |   |                                      |  |          |
| Maryland   |         |  |        |   |                            |  |                  |   |                                      |  |          |
| 13b. COUNTY  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| -  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| 13c. CITY OR TOWN  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| Baltimore  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| 13e. STREET ADDRESS  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| 31 N. Luzerne Ave.   |         |  |        |   |                            |  |                  |   |                                      |  |          |
| 14. FATHER'S NAME  |         |  |        |   |                            | 15. MOTHER'S MAIDEN NAME   |                  |   |                                      |  |          |
| FIRST MIDDLE LAST  |         |  |        |   |                            | FIRST MIDDLE LAST  |                  |   |                                      |  |          |
| Francesco Silvestri  |         |  |        |   |                            | (unknown)  |                  |   |                                      |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |  |        |   |                            | 16b. SOCIAL SECURITY NO.   |                  |   | 17. INFORMANT                        |  |          |
| No   |         |  |        |   |                            | 213-07-2923  |                  |   | Raymond Silvestri, son, 21222        |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| PART 1 DEATH WAS CAUSED BY:  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u>   |         |  |        |   |                            |  |                  |   |                                      |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |   |                            |  |                  |   |                                      |  |          |
| (b) _____  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |   |                            |  |                  |   |                                      |  |          |
| (c) _____  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| Diabetes mellitus  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| 19a. DATE OF OPERATION   |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                            |  |                  |   |                                      | 20. AUTOPSY?   |          |
|  |         |  |        |   |                            |  |                  |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/> |          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |                            |  |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |  |          |
|  |         |  |        | P.M. 19   |                            |  |                  |   |                                      |  |          |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |        | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |                            |  |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                      |  |          |
|  |         |  |        |   |                            |  |                  |   |                                      |  |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |        |   |                            |  |                  |   |                                      |  |          |
| ACTUAL SIGNATURE   |         |  |        | TITLE (SPECIFY)   |                            |  |                  | DATE SIGNED   |                                      |  |          |
| <u>H. Guard</u>  |         |  |        | M.D. Assistant  |                            |  |                  | 10/20/80  |                                      |  |          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |  |        | ADDRESS   |                            |  |                  |   |                                      |  |          |
| Hormez R. Guard, M.D.  |         |  |        | 111 Penn Street, Baltimore, MD 21201  |                            |  |                  |   |                                      |  |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                            |  |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                    |                                      |  |          |
| Burial   |         | 10/24/80   |        | Most Holy Redeemer  |                            |  |                  | Baltimore Md.   |                                      |  |          |
| 24. FUNERAL DIRECTOR   |         |  |        | 25. OCT 21 1980   |                            |  |                  | 26. SIGNATURE   |                                      |  |          |
| Schimunek Funeral Home, Inc.   |         |  |        | 3331 Brehms Lane Balto. Md., 21213  |                            |  |                  | <u>[Signature]</u>  |                                      |  |          |

MEDICAL CERTIFICATION

12-100

12-100

12-100

12-100

12-100

12-100

12-100

12-100

12-100

12-100

12-100

12-100

12-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 900-3131.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 7 0 2 5 8 3 6                                |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>FRED  |  | MIDDLE   |  | LAST<br>SIMMONS   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR                               |  |
|   |  |  |  |  |  |   |  | 10 25 80   |  | 2b. HOUR<br>534 A.M.                         |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Black  |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |  |
|   |  |  |  | 1 MONTH 10 DAY 1880  |  | 100 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                 |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)<br>Baltimore City Hosp. |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. CITY OR TOWN<br>Glen Burnie   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br>PO Box 933 Glen Burnie                             |  |  |  |  |  |
| 14 FATHER'S NAME  |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS<br>Beulah Spencer 7876 Tall Pines Ct.   |  |  |  |
| 14a. FIRST<br>Abram   |  | 14b. MIDDLE<br>Simmons   |  | 14c. LAST<br>Simmons   |  | 15a. FIRST<br>Julia   |  | 15b. MIDDLE<br>Brock   |  | 15c. LAST<br>Brock                           |  |
| 16a. NO   |  | 16b. NO  |  | 16c. NO  |  | 16d. NO   |  | 16e. NO  |  | 16f. NO                                      |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Unknown</u><br>4275<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cardiopulmonary arrest</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Kenneth L. Glick MD</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 |  |   |  | 22c. DATE SIGNED<br>10/25/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kenneth L. Glick MD  |  | 22e. ADDRESS<br>Balt City Hosp   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11/1/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co., Md.       |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H  |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                          |  |  |  |  |  |

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 3 7

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Grady Martin Simmons Sr.</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>10 28 1980</b>  |  |  |  | 2b. HOUR <b>11:15AM</b>   |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>N</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 26 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BAITIMORE</b> 13c. CITY OR TOWN <b>BAITIMORE</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |  |   |  | 13e. STREET ADDRESS <b>2424 Presbury Street</b>   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Simmons</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel McIntire</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS <b>Sarah F. Simmons 120 W. Phila Blvd Flint Michigan</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Cardio Resp Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>2 Cardiac Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>2<sup>nd</sup> ACVD.</b> |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/24/80</b> 19 <b>80</b> , to <b>10/28/80</b> 19 <b>80</b> , that (I) (we) lost <b>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.</b>  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>N. Merchant</b>   |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NOOR M. MERCHANT M.D.</b>  |  |   |  | 22e. ADDRESS <b>ST AGNES HOSPITAL</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (IF ANY) <b>Removal</b>   |  | 23b. DATE <b>11/1/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Grace Lawn</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Flint Michigan</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>WM. C. March Funeral Home Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 30 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Rita McBrady</b>   |  |   |  |

MEDICAL CERTIFICATION

9/9

BP

BALTIMORE CITY

ST AGNES HOSPITAL

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ST AGNES HOSPITAL

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MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 80 25838  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>David Michael Simms</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 10, 1980</b>  |  | 2b. HOUR<br><b>09:10pm</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 9, 1979</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>1</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>none</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN<br><b>Md. Cecil Elkton</b>  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>54 Stoney Chase Dr.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Calvin C. Simms</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary A. Fore</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-94-1870</b>  |  | 17. INFORMANT<br><b>Calvin C. Simms</b>  |  | ADDRESS<br><b>Elkton, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Tetralogy of Fallot</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 min.</b><br><b>2 days</b><br><b>9 months</b>                      |  |
|   |  |   |  |  |  |   |  |
|   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>10-8-80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Tetralogy of Fallot</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I (this hospital)) attended the deceased from <b>10-6</b> , 19 <b>80</b> , to <b>10-9</b> , 19 <b>80</b> , that (we) lost saw the deceased alive on <b>10-9</b> , 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Roger E. Schneider MD</b>  |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>10-9-80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Roger E. Schneider MD</b>   |  |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10-13-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>North East Methodist</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>North East Cecil Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Paul R. Crouch</b>   |  |   |  | ADDRESS<br><b>North East, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 15 1980</b>   |  |
|   |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Crouch</b>   |  |

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SECRET

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

30 25839

|  |             |  |   |   |                               |   |                                     |                                      |       |   |   |
|--|-------------|--|---|---|-------------------------------|---|-------------------------------------|--------------------------------------|-------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |             | FIRST  | MIDDLE  | LAST  | 2a. DATE OF DEATH             | KNOWN<br>ESTI-<br>MATED   | <input checked="" type="checkbox"/> | MONTH                                | DAY   | YEAR  | 2b. HOUR  |
| James I. Simpson Jr.   |             |  |   |   | 10                            | 26  | 19                                  | 80                                   |       |   | M   |
| 3. SEX   | 4. RACE     | 5. DATE OF BIRTH   | 6. AGE (IN YEARS<br>(LAST BIRTHDAY))  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.<br>HOURS MIN | 7c. DATE<br>PRONOUNCED<br>DEAD  | MONTH                               | DAY                                  | YEAR  | 2d. HOUR  |   |
| male   | black       | 4 24 39  | 41 YRS.   |   |                               | 10  | 26                                  | 19                                   | 80    | 8:47A   |   |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |             | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                     |                                      |       |   |   |
| MD   |             | USA  |   |   |                               | Baltimore City MD.  |                                     |                                      |       |   |   |
| 10. CITY OR TOWN OF DEATH  |             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                               | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |                                     | 12b. KIND OF BUSINESS<br>OR INDUSTRY |       |   |   |
| Baltimore  |             | Johns Hopkins Hospital   |   |   |                               |   |                                     |                                      |       |   |   |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| 13a. STATE   | 13b. COUNTY | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS   |                               |   |                                     |                                      |       |   |   |
| MD   |             | Baltimore  |   | 1627 E. Oliver St.  |                               |   |                                     |                                      |       |   |   |
| 14. FATHER'S NAME  |             |  |   | 15. MOTHER'S MAIDEN NAME  |                               |   |                                     |                                      |       |   |   |
| FIRST  |             | MIDDLE   |   | LAST  |                               | FIRST   |                                     | MIDDLE                               |       | LAST  |   |
| James  |             | I.   |   | Simpson Sr.   |                               | Helen   |                                     |                                      |       | Toran   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |             |  |   | 16b. SOCIAL SECURITY NO.  |                               | 17. INFORMANT ADDRESS   |                                     |                                      |       |   |   |
| No   |             |  |   | 216-32-1267   |                               | Helen Jones 1627 E. Oliver St.  |                                     |                                      |       |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:   |             |  |   |   |                               |   |                                     |                                      |       |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease  |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| 4029 { DUE TO, OR AS A CONSEQUENCE OF  |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| (c)  |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| 19a. DATE OF OPERATION   |             |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                               |   |                                     |                                      |       | 20. AUTOPSY?  |   |
|  |             |  |   |   |                               |   |                                     |                                      |       | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |             |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |                               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                     |                                      |       |   |   |
|  |             |  |   | P.M. 19   |                               |   |                                     |                                      |       |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |             |  |   | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |                               | 21f. LOCATION<br>STREET   |                                     | CITY OR TOWN                         |       | COUNTY  | STATE   |
|  |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |             |  |   |   |                               |   |                                     |                                      |       |   |   |
| ACTUAL SIGNATURE   |             |  |   | TITLE (SPECIFY)   |                               |   |                                     | DATE SIGNED                          |       |   |   |
| Hormez R. Guard, M.D.  |             |  |   | Assistant   |                               |   |                                     | 10/26/80                             |       |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |             |  |   | ADDRESS   |                               |   |                                     |                                      |       |   |   |
| Hormez R. Guard, M.D.  |             |  |   | 111 Penn Street, Balto., MD 21201   |                               |   |                                     |                                      |       |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |             | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CRYPTORY   |                               | 23d. LOCATION<br>CITY OR TOWN   |                                     | COUNTY                               | STATE |   |   |
| Burial   |             | 10/31/80   |   | Baltimore Cemetery  |                               | Baltimore   |                                     |                                      | MD    |   |   |
| 24. FUNERAL DIRECTOR<br>NAME   |             |  |   |   |                               | 25a. DATE REC'D. BY REGISTRAR   |                                     | 25b. REGISTRAR'S SIGNATURE           |       |   |   |
| Wm. C. March F/H 1101 E. North Ave.  |             |  |   |   |                               | OCT 27 1980   |                                     | [Signature]                          |       |   |   |

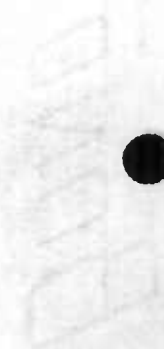
BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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Item 22a 5549 11/21/80 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 25840

FOR  
1- STATE  
REGISTRAR

|  |                         |   |  |   |  |  |   |   |                                  |
|--|-------------------------|---|--|---|--|--|---|---|----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Gary A. Singleton</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH <b>10</b> DAY <b>18</b> YEAR <b>80</b> |   |  | 2b. HOUR<br><b>M</b>   |   |   |                                  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>4</b> DAY <b>18</b> YEAR <b>57</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>23</b> YRS  | IF UNDER 1 YR.<br>MONTHS<br><b>0</b>  | IF UNDER 24 HRS.<br>HOURS<br><b>0</b> MIN.<br><b>0</b>   | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>10</b> DAY <b>18</b> YEAR <b>80</b>         |   |   | 7d. HOUR<br><b>9:00</b> <b>M</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Del.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> <b>MD.</b>         |   |   |                                  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital-S.T.U.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Garage</b>                                  |                                  |
| 13a. STATE<br><b>Del.</b>  |                         |   | 13b. CITY OR TOWN<br><b>Dover</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13c. STREET ADDRESS<br><b>24 Carlisle Dr.</b>   |   |                                  |
| 14. FATHER'S NAME<br>FIRST <b>LeRoy</b> MIDDLE <b>Singleton</b> LAST <b>Singleton</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Pearl</b> MIDDLE <b>Rodbell</b> LAST <b>Singleton</b>                               |   |  | 16. ADDRESS<br><b>24 Carlisle Dr. Dover. Del.</b>                                |   |   |                                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>221-38-9560</b>   |   | 17. INFORMANT<br><b>Susan D. Singleton</b>   |  |   |   |                                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cranio-cervical injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |                         |   |  |   |  |  |   |   |                                  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |  |  |   |   |                                  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7:46 10 17 80</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject was driver of auto which was struck by train</b> |  |   |   |                                  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Conrail tracks</b>                                     |   | 21f. LOCATION<br>STREET<br><b>Dover,</b> CITY OR TOWN<br><b>Delaware</b> COUNTY STATE  |  |   |   |                                  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Motor Vehicle - Accident</b> <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |  |   |   |                                  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>  |   |  | DATE SIGNED<br><b>10-19-80</b>   |   |   |                                  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                         |   | ADDRESS<br><b>111 Penn Street</b>  |   |  |  |   |   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>10-21-80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Dover</b> COUNTY<br><b>Kent</b> STATE<br><b>Del</b> |   |                                  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Paul J. ...</i>   |                         |   | ADDRESS<br><i>1411 W. ...</i>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>...</i>  |   |                                  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



DO NOT WRITE IN THESE SPACES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 8025841                                |  |          |  |
|--|--|--|--|---|--|--|--|---|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                       |  |   |  |   |  | 2b. HOUR |  |
| 1 DECEASED NAME (TYPE OR PRINT) <b>KATTIE SINGLETON</b>  |  |  |  |   |  | 10/8/80  |  |   |  |   |  | 8:10 PM  |  |
| 3 SEX <b>FEMALE</b>  |  | 4 RACE <b>BLK</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 25, 1900</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS                           |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                     |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.          |  |   |  |   |  |          |  |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Provident Hospital</b> |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>  |  |  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>                                     |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS <b>4214 Fernhill Avenue</b> |  |          |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Robert Gilyard</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unk.</b>  |  |  |  |   |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>   |  | 17. INFORMANT ADDRESS <b>Lucille Clinton 4214 Fernhill Avenue</b>      |  |   |  |   |  |          |  |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>   |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |          |  |
| 2765 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>POSS. CARDIOGENIC SHOCK</b>   |  |  |  |   |  |  |  |   |  |   |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>DEHYDRATION &amp; CONGESTIVE FAILURE</b>   |  |  |  |   |  |  |  |   |  |   |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  |  |  |  |   |  |  |  |   |  |   |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  |   |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/8/80</b> , 19 <b>80</b> to <b>10/8</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/8/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |          |  |
| 22b. SIGNATURE <b>DR ABUSY</b>   |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>10/8/80</b>                 |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR ABUSY</b>  |  |  |  | 22e. ADDRESS <b>PROVIDENT HOSPITAL</b>  |  |  |  |   |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>10/16/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mt. Pleasant S.C.</b>       |  |   |  |   |  |          |  |
| 24 FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>   |  |  |  | ADDRESS <b>1101 E. North Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |  |          |  |

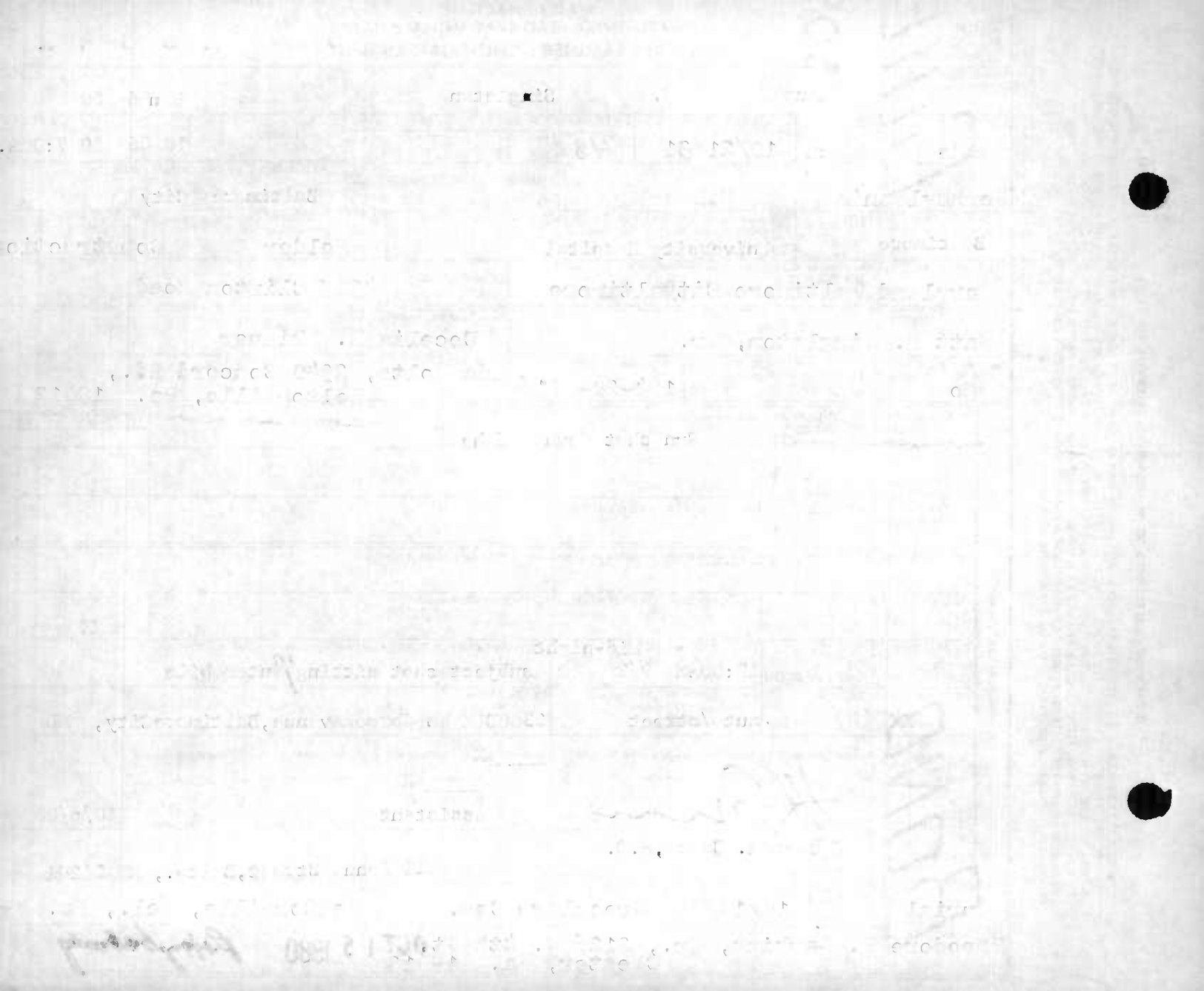
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |  |   |  |   |  |   |  | REG. NO. 80 25842  |  |
|--|---------|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE KNOWN OF DEATH   |  |   |  |   |  | 2b. HOUR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  |  | LAST  |  | DATE KNOWN OF DEATH   |  | HOUR   |  |
| Ronald   |         | E.  |  | Singleton   |  |   |  | 10 06 19 80   |  | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD  |  | 7d. HOUR   |  |
| male   | black   | 10/21/31  |  | 48 YRS.   |  |   |  | 10 06 19 80   |  | 7:00A.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| Pennsylvania   |         | USA   |  | WIDOWED   |  | DIVORCED  |  | Baltimore City MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore  |         | University Hospital   |  |   |  | Welder  |  | Construction  |  |  |  |
| 13a. STATE   |         |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |  |  |
| Maryland   |         |   |  | Baltimore   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |  |
| 14. FATHER'S NAME  |         |   |  | 15. MOTHER'S MAIDEN NAME                                    |  |   |  | 16a. SOCIAL SECURITY NO.  |  |  |  |
| Watt H. Singleton, Sr.   |         |   |  | Cecelia E. Skinner  |  |   |  | 16b. ADDRESS  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |   |  | 16b. SOCIAL SECURITY NO.                                    |  |   |  | 16c. ADDRESS  |  |  |  |
| No   |         |   |  | 194-20-8716   |  |   |  | Ada Holtz, 2340 Concord Rd., Feltonville, Pa. 19013                           |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I DEATH WAS CAUSED BY:  |         |   |  |   |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u>  |         |   |  |   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |   |  |   |  |   |  |   |  |  |  |
| (b)  |         |   |  |   |  |   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |   |  |  |  |
| (c)  |         |   |  |   |  |   |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  | 20. AUTOPSY?  |  |  |  |
|  |         |   |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |  |
| 21a. EXTERNAL CAUSE WAS  |         |   |  | 21b. TIME OF INJURY   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |   |  | 12:00AM 9/2 19 80   |  |   |  | subject shot sitting in automobile  |  |  |  |
| 21d. INJURY OCCURRED   |         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  | 21f. LOCATION   |  |  |  |
| WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |   |  | auto/street   |  |   |  | 2300BLK Woodbrook Avenue, Baltimore City, MD                                  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on  |         |   |  |   |  |   |  |   |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE   |         |   |  | TITLE (SPECIFY)   |  |   |  | DATE SIGNED   |  |  |  |
| Hormez R. Guard, M.D.  |         |   |  | Assistant   |  |   |  | 10/6/80   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |  | ADDRESS   |  |   |  |   |  |  |  |
|  |         |   |  | 111 Penn Street, Balto., MD 21201                           |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                          |  | 23d. LOCATION   |  | 23e. DATE REC'D. BY REGISTRAR   |  |  |  |
| Burial   |         | 10/10/80  |  | Greenlawn Cem.  |  | Feltonville, Del., Pa.  |  | OCT 15 1980   |  |  |  |
| 24. FUNERAL DIRECTOR   |         |   |  |   |  |   |  |   |  |  |  |
| Theodore F. Hawkins, Jr., 2126 W. 4th St, Chester, Pa. 19013   |         |   |  |   |  |   |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the decedent be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 8 0 2 5 8 4 3                              |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br><b>LELA</b>   |  | MIDDLE  |  | LAST<br><b>SKIPPER</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/28/80</b>   |  | 2b. HOUR<br>10:00a<br>M                    |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 20 23</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>57</b>  |  | IF UNDER 24 HRS<br>HOURS MIN.<br><b>57</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1748 Lewelyn Avenue</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Russell Davis</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie Harris</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Clarence Davis 1748 Lewelyn Avenue</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST 2° TO RESP. FAILURE</b><br>3030 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HEPATIC ENCEPHALOPATHY, GI BLEED</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC ALCOHOLISM, ACUTE RENAL FAILURE</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b> |  |  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1/6<br><b>CHRONIC PANCREATITIS, PERITONITIS, DIABETES, COAGULOPATHY/DIC</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/27/80</b> , 19____, to <b>10/28/80</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>10/27/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>L D Snyder MD</b>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>10/28/80</b>   |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L D SNYDER</b>   |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSP.</b>   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/1/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Churchhill Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lawrenceville VA</b>                           |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March Funeral Home Inc.</b>  |  | ADDRESS<br><b>1101 E. North Ave</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. Snyder</b>  |  |  |  |  |  |

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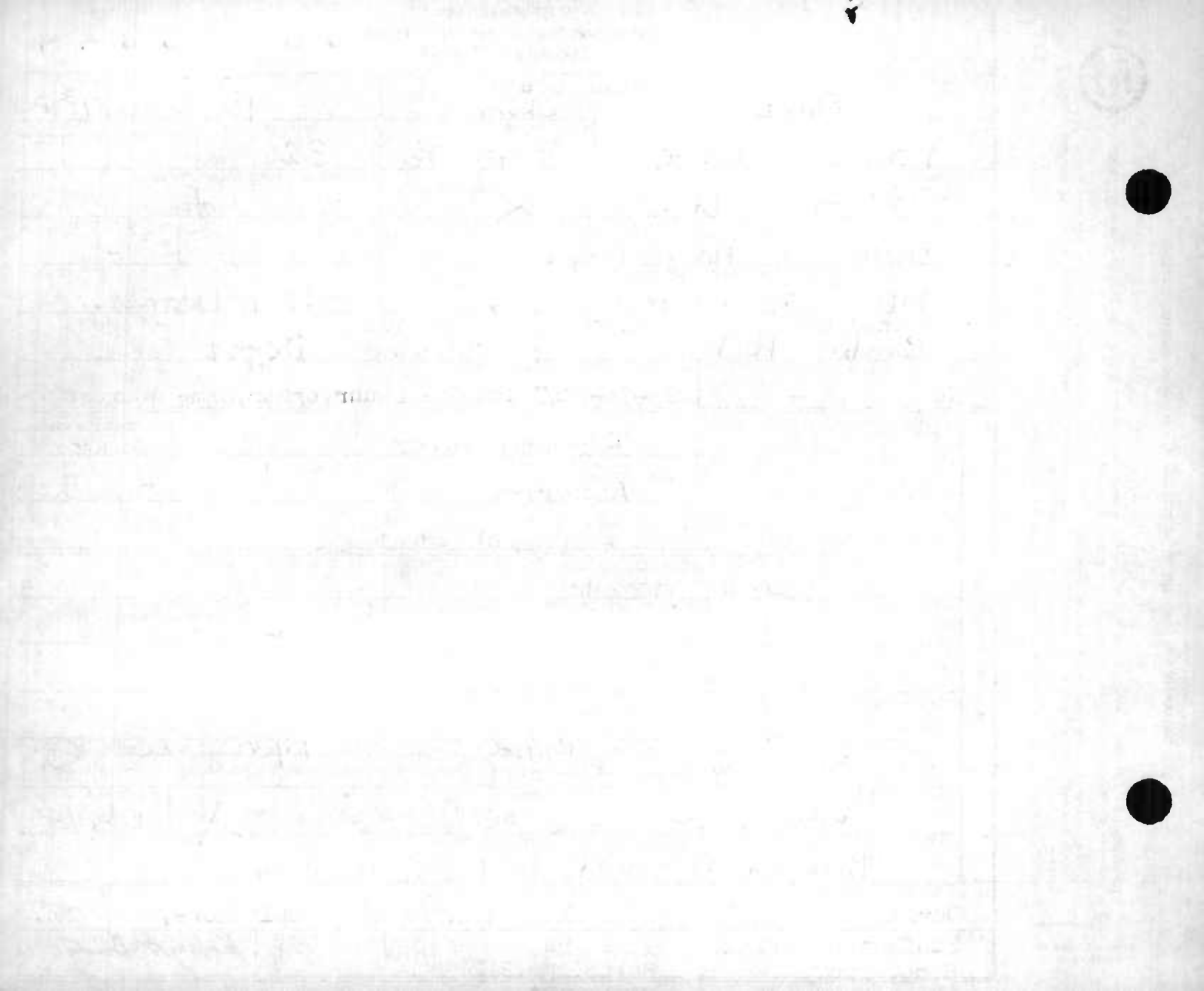
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 5 8 4 4<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) Marie Catherine Skuhr<br>MARIE Skuhr   |  |   |  | 2b. DATE OF DEATH<br>10 30 80 9 30 P.M.   |  |  |  |
| 3 SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>5 18 98   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |
| 13a. STATE<br>MD   |  |   |  | 13b. COUNTY<br>Balto  |  | 13c. CITY OR TOWN<br>Balto   |  |
| 14. FATHER'S NAME<br>Cornelius Paetow<br>Cornelius Paetow  |  |   |  | 15. MOTHER'S NAME<br>Catherine Diegert<br>Catherine Diegert   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No  |  |   |  | 16b. SOCIAL SECURITY NO.<br>213-74-7047   |  | 17. INFORMANT<br>Cecelia Skuhr, dgtr, same address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>5303 IMMEDIATE CAUSE (a) Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Aspiration<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Esophageal Stricture<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>day 5 - hours |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>senile dementia   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/9/80, 19, to 10/30, 19 80, that (I) (we) lost saw the deceased alive on 10/30, 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Patricia D. Smith MD   |  | 22c. DATE SIGNED<br>10/30/80  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>PATRICIA D. SMITH  |  |  |  |
| 22e. ADDRESS<br>MERCY HOSPITAL   |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/3/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem. Park   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |  | 24. FUNERAL DIRECTOR<br>Schlimmek Funeral Home, Inc.  |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 5 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony M. ...   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 5 8 4 5<br>REG. NO.   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Charles Slaughter</i>   |  |  |  | 2b. HOUR <i>2:35 P.M.</i>   |  |   |  |
| 3. SEX<br><i>male</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>12-27-11</i>  |  | 6. AGE <i>68</i> YEARS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital</i> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><i>md.</i>  |  |  |  | 13b. COUNTY<br><i>Baltimore</i>   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>unk</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>unk</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>unk</i>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>212058533</i>  |  | 17. INFORMANT ADDRESS<br><i>Florida Slaughter (same)</i>  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchogenic Cancer metastases</i><br><i>1629</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/22</i> 19 <i>80</i> , to <i>10/5</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10/5</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |   |  |
| 22b. SIGNATURE <i>Moges Gebremariam</i> DEGREE  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED <i>10/5/80</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MOGES GEBREMARIAM</i>   |  |  |  | 22e. ADDRESS<br><i>Lutheran Hosp of Md.</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>10/9/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>MT. AUBURN Cem</i>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>BALTO. MD.</i>  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Chas. H. Powell F/H</i>   |  |  |  | ADDRESS<br><i>319 N. Schroeder St.</i>  |  | 25a. DATE REC'D. BY REGISTRAR <i>1980 OCT 8</i>   |  |

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X

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO. 8 0 2 5 8 4 6                       |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Helen S. SLOAT</b>  |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 22, 1980</b>   |  | 2b. HOUR<br><b>11:10 P.M.</b>                |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 18, 1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 74 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b>           |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md. Gen. Hosp. St.</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>615 Homestead</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Godfrey Seton</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Susie Davis</b>  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>577 18 5726</b>   |  | 17. INFORMANT<br><b>Linda Real</b>  |  | ADDRESS<br><b>Balto., Md.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Of The Esophagus</b><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 17, 19 80</b> , to <b>October 22, 19 80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 22, 19 80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Talal R. Almuhtaseb M.D.</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>10-23-80</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Talal Almuhtaseb, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/27/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Woodlawn, Md.</b>                              |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 24 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |  |  |
| 4905 York Road Balto., Md. 21212  |  |  |  |   |  |  |  |   |  |  |  |

10-11-50

October 11, 1950

Mr. J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C.

Dear Mr. Hoover:

I am writing to you regarding the matter of the

investigation of the

activities of the

organization known as the

Communist Party, U.S.A.

I am enclosing for you a copy of the

report of the investigation of the

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Charity Smith   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 9 80 |   |  | 2b. HOUR<br>2:55 P.M.  |  |
| 3. SEX<br>F  |  | 4. RACE<br>B   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>2 28 13  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>67 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  |
| 13a. STATE<br>Md   |  |  |   | 13b. COUNTY<br>BALTO  |  | 13c. STREET ADDRESS<br>145 W Hamburg St  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>HARRY SMITH   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ida Leatherberry  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-18-8383  |   | 17. INFORMANT<br>Ida E Welsh 7404 Allmont Rd  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>respiratory compromise</u><br>5772 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>massive ascites</u><br>(c) <u>pancreatic pseudocyst</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>anemia, oliguric renal failures, alcoholic cirrhosis</u> |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 wk<br>3 mos<br>unknown |
| 19a. DATE OF OPERATION<br>—  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY N/A<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>N/A   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-17, 1980, to 10-9, 1980, that (I) (we) last saw the deceased alive on 10-9, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br>Raymond E Gangarosa MD   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>10-9-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Raymond Eugene Gangarosa  |  |  |   | 22e. ADDRESS<br>University of Maryland Dept of Medicine, Balto.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10-14-1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD   |  |
| 24. FUNERAL DIRECTOR NAME<br>BROWN-THOMPSON  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>R. J. [Signature]  |  |
| 25c. NAME OF FUNERAL HOME<br>TSPARK L. BROWN & SON 1913 W. Balto St  |  |  |   |   |  |  |  |

MEDICAL CERTIFICATION

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1930 OCT 14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |                                      |  |   |  |   |  |
|---|--|--|--|--|--|--------------------------------------|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 7. REG. NO.  |  | 8 0 2 5 8 4 8  |  |                                      |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST                                 |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR P M  |  |
| CLATER  |  | W.   |  | SMITH  |  | SR.                                  |  | October 2, 1980   |  | 1:55 P  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN.  |  |
| Male  |  | White  |  | Mar. 6, 1901   |  | 79 YRS.                              |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |   |  |
| N. Carolina   |  | USA  |  |  |  | Baltimore City MD.                   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |                                      |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Baltimore   |  | 100 W. University Pkwy. #8B  |  |  |  |                                      |  | Attorney  |  | Law   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a. STATE   |  | 13b. COUNTY                          |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| Maryland  |  |  |  |  |  | Baltimore                            |  |   |  | 13e. STREET ADDRESS   |  |
|   |  |  |  |  |  |                                      |  | 100 W. University Pkwy. #8B   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |                                      |  |   |  |   |  |
| Clater W. Smith   |  |  |  | Mae Maulitsy   |  |                                      |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT ADDRESS                |  |   |  |   |  |
| No  |  |  |  |  |  | Mrs. Clater W. Smith, Sr. Same       |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Moderately well differentiated</u>   |  |  |  |  |  |                                      |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 2001 } DUE TO, OR AS A CONSEQUENCE OF <u>Lymphocytic lymphoma</u>   |  |  |  |  |  |                                      |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |                                      |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |                                      |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                      |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |                                      |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>December 1975</u> to <u>October 2, 1980</u> , that (I) (we) last saw the deceased alive on <u>September 23, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |                                      |  |   |  |   |  |
| 22b. SIGNATURE <u>Dr. Isabelle MacGregor</u>  |  |  |  | DEGREE <u>MD</u>   |  |                                      |  | 22c. DATE SIGNED <u>10.3.80</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |                                      |  |   |  |   |  |
| Dr. Isabelle MacGregor, M.D.  |  |  |  | 11 E. Chase St., Balto., Md.   |  |                                      |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| Burial  |  |  |  | 10/6/80  |  | Druid Ridge                          |  | Pikesville, Md.   |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 24b. ADDRESS   |  |                                      |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Henry W. Jenkins & Sons Co.   |  |  |  | 4905 York Road, Balto., Md. 21212  |  |                                      |  | OCT 3 1980  |  | <u>Robert McBrady</u>   |  |



100 W. University Pkwy. 2120  
Baltimore, Maryland  
Clarke W. Smith  
Mrs. Clarke W. Smith, Sr.  
100 W. University Pkwy. 2120  
Baltimore, Maryland  
Clarke W. Smith  
Mrs. Clarke W. Smith, Sr.  
100 W. University Pkwy. 2120  
Baltimore, Maryland  
Clarke W. Smith  
Mrs. Clarke W. Smith, Sr.

1505 York Road, Baltimore, Md. 21212  
Harry W. Jenkins & Sons Co.  
Baltimore, Md. 21201  
Dr. Isabelle MacGregor, M.D., 11 E. Chase St., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 4 9

REG. NO.

|  |                                     |   |                                |   |   |
|--|-------------------------------------|---|--------------------------------|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Florence Smith   |                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 10 80   |                                | 2b. HOUR<br>10 <sup>45</sup> A.M.   |   |
| 3. SEX<br>F  | 4. RACE<br>B                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 5 03  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1506 Holbrook St.                              |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   |
| 13a. STATE<br>MD   |                                     | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Josh Marshall  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Singer Matthews  |                                |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |                                     | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-18-9984  |                                | 17. INFORMANT<br>ADDRESS<br>D George Marshall 1506 Holbrook St.                                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>brainstem cerebrovascular accident</u><br>4280<br>DUE TO, OR AS A CONSEQUENCE OF -<br>(b) <u>hypoperfusion</u><br>36 hours<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>congestive heart failure</u><br>23 years                  |                                     |   |                                |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>aortic stenosis/regurgitation, Kaposi's sarcoma, bullous pemphigoid (on steroids)</u>  |                                     |   |                                |   |   |
| 19a. DATE OF OPERATION<br>N/A  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-10</u> , 19 <u>80</u> , to <u>10-10</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                                     |   |                                |   |   |
| 22b. SIGNATURE<br>RE Gangarosa MD  |                                     | DEGREE  |                                | 22c. DATE SIGNED<br>10-10-80  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RE Gangarosa  |                                     | 22e. ADDRESS<br>University of Maryland Hospital, Balto., Md.  |                                |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                                     | 23b. DATE<br>10/15/80   |                                | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |   |
| 23d. LOCATION<br>CITY OR TOWN<br>Baltimore   |                                     | COUNTY<br>MD  |                                | STATE   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |                                     | ADDRESS<br>1101 E. North Ave.   |                                | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |   |

*RE Gangarosa*

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*Handwritten signature or initials*

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Francis Mae Smith</u>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>10-28-80</u>                  |   | 2b. HOUR<br>M<br><u>AM</u>   |
| 3. SEX<br><u>Female</u>  | 4. RACE<br><u>Blk</u>                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>10-8-1932</u>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>48</u> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>MD</u>  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>City</u> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTO</u>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>619 Brice St</u>                            |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><u>MD</u>  |   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><u>BALTO</u>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Lawrence Green</u>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Margaret Tugood</u> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br><u>Ellen Green 2322 Druid Pk Dr</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>1509</u> IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA of Esophagus &amp; OROPHARYNX -</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>- Severe dehydration</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 months</u> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>80</u> , to <u>Oct. 27</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Oct. 27</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Johnny D. Pierce</u>  |   | DEGREE<br><u>MD</u>   |   | 22c. DATE SIGNED<br><u>10/31/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Johnny D. Pierce</u>   |   | 22e. ADDRESS<br><u>University of Maryland Hospital</u>  |   | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>  |   | 23b. DATE<br><u>11-3-80</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arbutus</u>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTO MD</u>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>VERNON R Bailey</u>   |   | ADDRESS<br><u>1348 N. CALHOUN ST</u>  |   | 25a. DATE REC'D. BY REGISTRAR<br><u>NOV 6 1980</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 80 25851

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR                                |   |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR                                |   |
| Festus Smith  |   | 10 14 1980  |   | 12:25 P.M.                              |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)   | 7. IF UNDER 1 YR.                       | 8. IF UNDER 24 HRS.   |
| Male  | Black   | 7/2/1899  | 81 YRS.   |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                                | 8. MARRIED  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH    |   |
| Hardy Co., N.C.   | U.S.A.  | Sep   |   | Baltimore City                          |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |   | 12b. KIND OF BUSINESS OR INDUSTRY       |   |
| Baltimore   | 323 N. Charles Street                                       | Retired   |   | Construction                            |   |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                     |   |
| Md.   |   | Balto.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1610 Edmondson Avenue                   |   |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                    |   |   |   |   |
| Steven Smith  | Elizabeth McLean  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.                                    | 17. INFORMANT ADDRESS   |   |   |   |
| no  | 217 05 8310   | Arthur Smith 2503 White Oak Dr.   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART I DEATH WAS CAUSED BY:   |   |   |   |   |   |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>  |   |   |   |   |   |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |   |   |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |   |   |   |   |   |
| (b) _____   |   |   |   |   |   |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |   |   |   |
| (c) _____   |   |   |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |   |   | 20. AUTOPSY?  |
|   |   |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |   |
|   | P.M. 19   |   |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |   |   |   |   |   |
| ACTUAL SIGNATURE  |   | TITLE (SPECIFY)   |   | DATE SIGNED                             |   |
| <u>Margareta Dr. Whell</u>  |   | Assistant   |   | 10-14-80                                |   |
| EXAMINER'S NAME (TYPE OR PRINT)   |   | ADDRESS   |   |   |   |
| Margarita A. Korell, M.D.   |   | 111 Penn Street   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE |   |
| Burial  | 10/18/80  | King Mem  |   | Randallstown Md.                        |   |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE              |   |
| Jas. A. Morton & Sons   |   | OCT 17 1980   |   | <u>John A. Morton</u>                   |   |
| 1701 Laurens St.  |   |   |   |   |   |

OCT 17 1980

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 5 8 5 2   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| GEORGE L. SMITH   |  |  |  | MONTH DAY YEAR<br>10 26 80  |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 1 1952  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>28 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNEMPLOYED  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MARYLAND  |  |  |  | 13b. COUNTY   |  |  |  |
| 13c. CITY OR TOWN<br>BALTIMORE  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 13e. STREET ADDRESS<br>610 CATOR AVE.   |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RICHARD SMITH   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGAURITA GREGORY   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-60-8555   |  | 17. INFORMANT<br>ADDRESS<br>MARGAURITA SMITH 610 CATOR AVE.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shock<br>5712 DUE TO, OR AS A CONSEQUENCE OF<br>(b) GI bleeding<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Esophageal Varices, Alcoholic Gastritis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 hrs<br>2 weeks<br>chronic |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Cirrhosis, Alcoholism, Portal Hypertension   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>NONE  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (a) this hospital attended the deceased from 10/22, 19 80, to 10/26, 19 80, that (b) (we) lost saw the deceased alive on 10/26, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (c) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>James C Jarrell MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>10/26/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James C Jarrell MD   |  |  |  | 22e. ADDRESS<br>Union Mem'l Hosp, 201 E. Univ Pkwy, Balt, MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>REMOVAL   |  | 23b. DATE<br>10-30-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SECOND MT. ZION CH.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CAROLINE COUNTY VIRGINIA   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>1721-27 N. MONROE ST.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

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UNITED STATES

UNITED STATES

UNITED STATES

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 5 3

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HENRY C. SMITH</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCT. 18, 1980</b> |   | 2b. HOUR<br><b>10:36p</b>                                       |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Negro</b>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 30 20</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.                 | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>                  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |   |   |   |
| 13a. STREET ADDRESS<br><b>1213 N. Decker St.</b>   |  |   |   |   |   |
| 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |   |
| 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |   |   |   |   |
| 13d. STATE<br><b>MD</b>  |  |   |   |   |   |
| 13e. COUNTY<br><b>Baltimore</b>  |  |   |   |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander Smith</b>   |  |   |   |   |   |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hattie Spell</b>   |  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |   |   |   |
| 16b. SOCIAL SECURITY NO.<br><b>240-03-8618</b>   |  |   |   |   |   |
| 17. INFORMANT<br>ADDRESS<br><b>Helen C. Smith 1213 N. Decker St.</b>   |  |   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5308</b> IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>esophageal max c prophageal renal fistula</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) |  |   |   |   |   |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  |   |   |   |   |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   |   |   |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   |   |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |   |   |   |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |   |   |   |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |   |   |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>16 Oct 1980</b> to <b>18 Oct 1980</b> , that (I) (we) last saw the deceased alive on <b>18 Oct 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |
| 22b. SIGNATURE<br><b>GB Vogelsang MD</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |   |   |   |
| 22c. DATE SIGNED<br><b>18 Oct 80</b>   |  |   |   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GB Vogelsang MD</b>  |  |   |   |   |   |
| 22e. ADDRESS<br><b>Johns Hopkins Hospital MD</b>   |  |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   |   |   |   |
| 23b. DATE<br><b>10/24/80</b>   |  |   |   |   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>  |  |   |   |   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |  |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |   |   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1980</b>  |  |   |   |   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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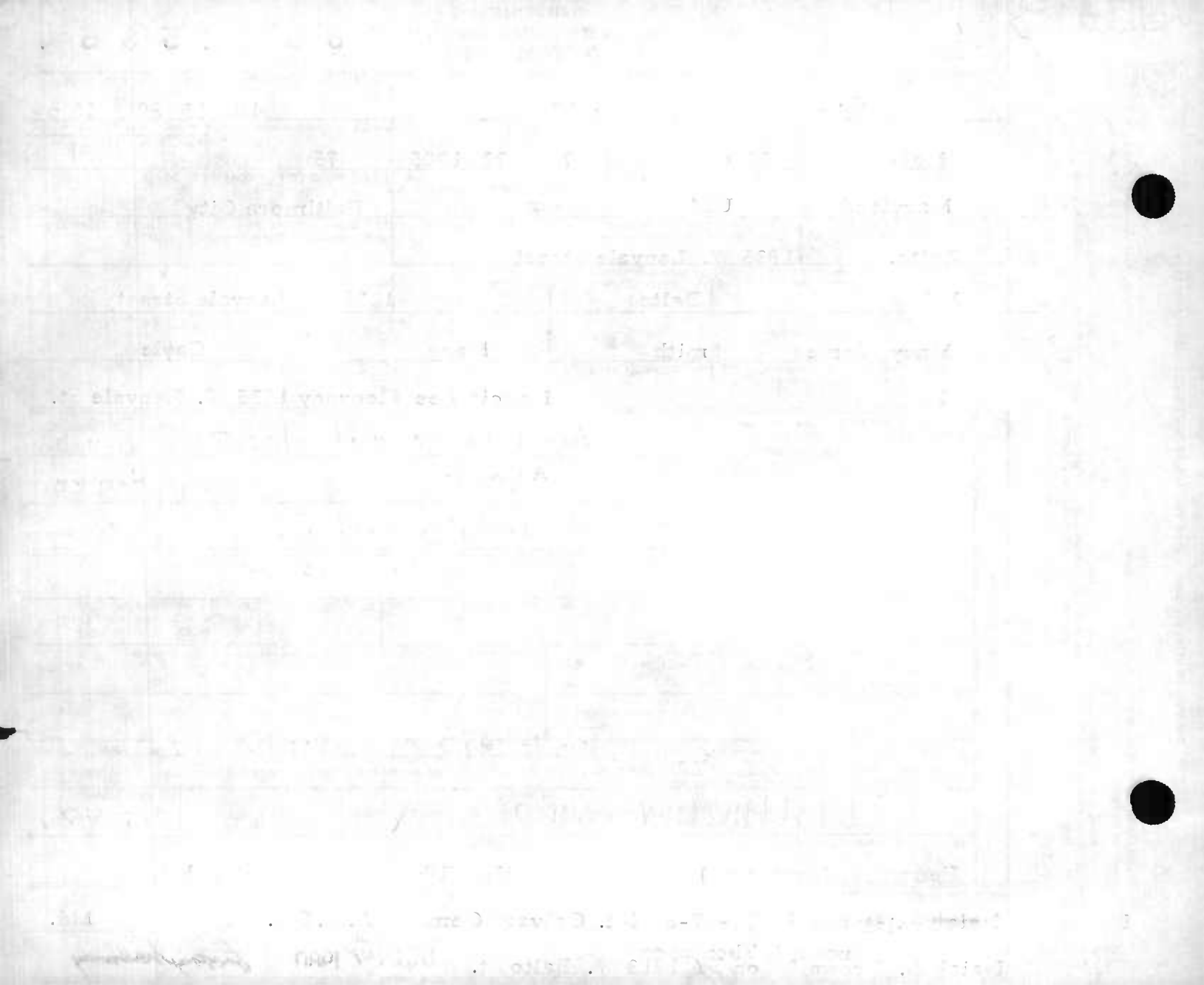
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 5 8 5 4<br>REG. NO.   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>John Smith</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 13 80</b>  |  |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 22 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1835 W. Lanvale Street</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>1835 W. Lanvale Street</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mr. James Smith</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Gayle</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>ADDRESS<br><b>Marcia Dee Flourney 1835 W. Lanvale St.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Ascorb</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) <b>Diabetes mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Diabetes mellitus</b><br>(c) <b>Hypertension</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b><br><b>years</b>  |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Feb. 16/1973</b> to <b>Oct 10</b> 19 <b>80</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 10/80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Henry Armanas</b> MD  |  |  |  | 22c. DEGREE<br><b>MD</b>  |  | 22d. DATE SIGNED<br><b>Oct 14/80</b>   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Henry Armanas MD</b>   |  |  |  | 22f. ADDRESS<br><b>1934 Wilkens Ave. Balto., Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10-17-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>A.A.CO. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Brown &amp; Thompson</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Isaiah L. Brown</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Isaiah L. Brown &amp; Son PA</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Isaiah L. Brown</b>   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

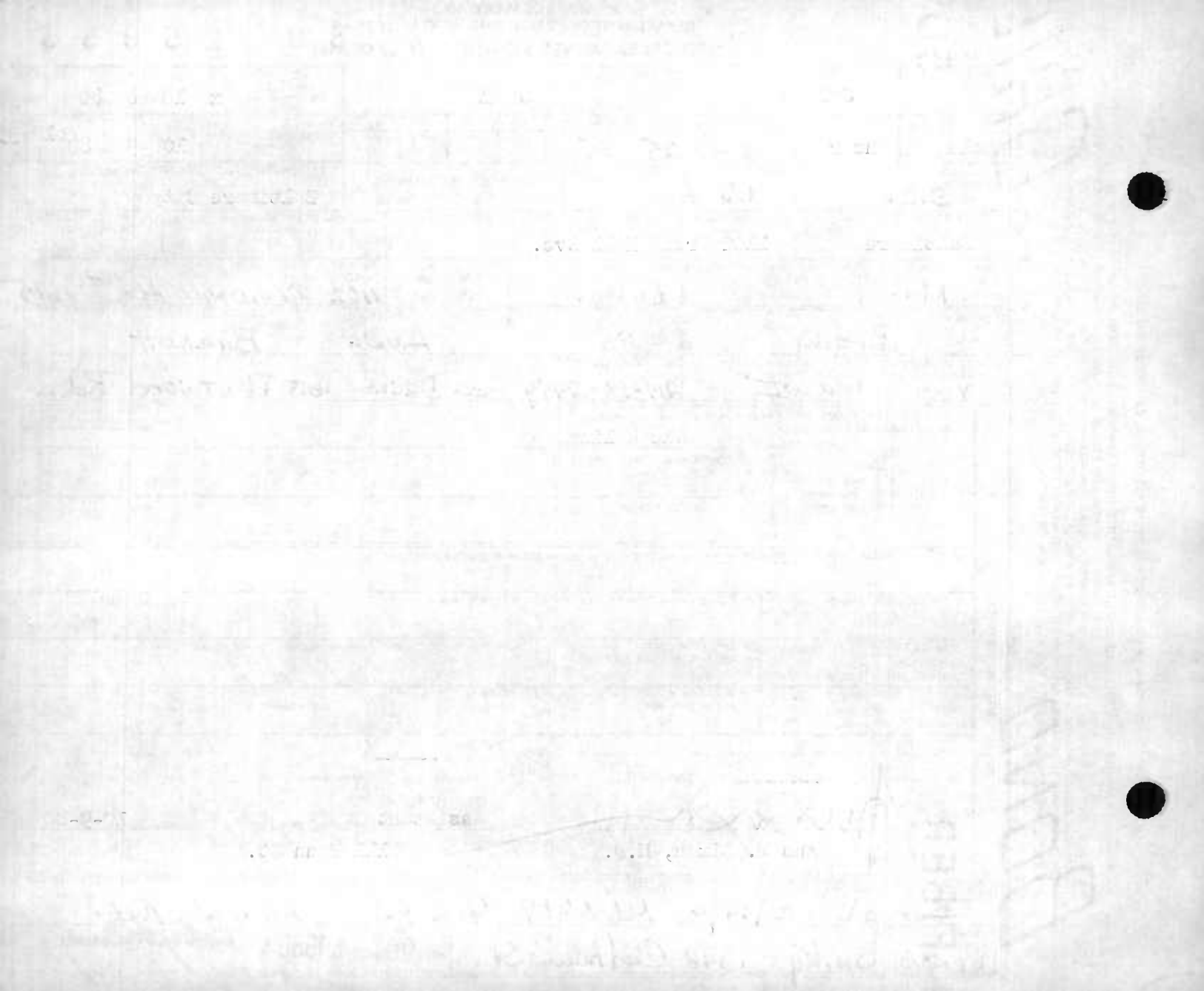
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 25855

|   |   |   |                                      |                             |               |
|---|---|---|--------------------------------------|-----------------------------|---------------|
| 1- FOR STATE REGISTRAR  |   | 2a. DATE KNOWN OF DEATH   |                                      | 2b. HOUR                    |               |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | 2c. DATE ESTIMATED  |                                      | 2d. HOUR                    |               |
| JOSEPH SMITH  |   | 10 8 19 80  |                                      | 12:35 p M                   |               |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)      | 7. CITIZEN OF WHAT COUNTRY? | 8. MARRIED    |
| male  | negro   | 3-6-25  | 55 YRS.                              | U.S. A.                     | NEVER MARRIED |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED  | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH   |               |
| S.C.  | U.S. A.   | WIDOWED   | Baltimore City                       | Baltimore                   |               |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                 | 12b. KIND OF BUSINESS OR INDUSTRY   | 13. CITY OR TOWN                     |                             |               |
| 1102 Druid Hill Ave.  |   |   | Balto.                               |                             |               |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)             |                                      |                             |               |
| Brady   | Anna Burkett  | YES   |                                      |                             |               |
| 17. INFORMANT   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                     | 19. SOCIAL SECURITY NO.   |                                      |                             |               |
| Geo. Davis  | Alcoholism  | 214-18-2444   |                                      |                             |               |
| 1615 Pentwood Rd.   | 303 -   | 20. AUTOPSY?  |                                      |                             |               |
|   | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | YES   |                                      |                             |               |
|   |   | NO  |                                      |                             |               |
|   |   | X   |                                      |                             |               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |   |   |                                      |                             |               |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   | 20. AUTOPSY?  |                                      |                             |               |
|   |   | YES   |                                      |                             |               |
| 21a. EXTERNAL CAUSE WAS   | 21b. TIME OF INJURY   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |                             |               |
| UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   | HOUR A.M. MONTH DAY YEAR  |   |                                      |                             |               |
|   | P.M. 19   |   |                                      |                             |               |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                   | 21f. LOCATION   |                                      |                             |               |
| WHILE AT WORK   |   | STREET CITY OR TOWN COUNTY STATE  |                                      |                             |               |
| NOT WHILE AT WORK   |   |   |                                      |                             |               |
| 22a. I certify that I took charge of the remains described above, held on   |   |   |                                      |                             |               |
| Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion  |   |   |                                      |                             |               |
| death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |                                      |                             |               |
| TITLE (SPECIFY)   |   |   |                                      |                             |               |
| Assistant   |   |   |                                      |                             |               |
| DATE SIGNED 10-9-80   |   |   |                                      |                             |               |
| EXAMINER'S NAME (TYPE OR PRINT)   |   |   |                                      |                             |               |
| Ann M. Dixon, M.D.  |   |   |                                      |                             |               |
| ADDRESS   |   |   |                                      |                             |               |
| 111 Penn St.  |   |   |                                      |                             |               |
| 23a. BURIAL, CREMATION, REMOVAL   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION                        |                             |               |
| Burial  | 10/14/80  | Md. Nat'l. Mem. Pk.   | LAUREL, Md.                          |                             |               |
| 24. FUNERAL DIRECTOR  | 25a. DATE REC'D. BY REGISTRAR   | 25b. REMAINS SHOWN TO   |                                      |                             |               |
| Genon Bailey  | 1348 Calhoun St.  | OCT 15 1980   |                                      |                             |               |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 5 6

REG. NO.

|   |  |  |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |  |  | 10 28 80   |  |  | 11:00 PM  |  |  |
| MARSHALL H. SMITH JR.   |  |  |  |  |  |  |  |  |   |  |  |
| 3 SEX   |  |  | 4 RACE   |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  |
| MALE  |  |  | WHITE  |  |  | MONTH DAY YEAR   |  |  | IF UNDER 1 YEAR IF UNDER 24 HRS                                     |  |  |
|   |  |  |  |  |  | 09 19 25   |  |  | 55 YRS.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| MARYLAND  |  |  | U.S.A.   |  |  |  |  |  | BALTIMORE CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| BALTIMORE   |  |  | 3108 GEORGETOWN ROAD   |  |  | MAINTENANCE  |  |  | SOLO CUP CORP.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. STATE   |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS?  |  |  |
|   |  |  | MARYLAND   |  |  | BALTIMORE  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 13e. STREET ADDRESS  |  |  |   |  |  |
| FIRST MIDDLE LAST   |  |  | FIRST MIDDLE LAST  |  |  | 3108 GEORGETOWN ROAD, 21230  |  |  |   |  |  |
| MARSHALL H. SMITH SR.   |  |  | IRENE HOFFMAN  |  |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO  |  |  | 17. INFORMANT  |  |  | ADDRESS   |  |  |
| YES   |  |  | WW II  |  |  | 219-14-1413  |  |  | OLIVER C. SMITH 110 BON AIR ROAD 21225                              |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic cerebral dysfunction</u>   |  |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxia</u>  |  |  |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction - Post Resuscitation</u>  |  |  |  |  |  |  |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Malnutrition</u>  |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |   |  |  |
|   |  |  | P.M. 19  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY   |  |  | 21f. LOCATION  |  |  |   |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE  |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  |  | 22c. DATE SIGNED  |  |  |
| <u>Jeffrey Abrams</u>   |  |  | M.D.   |  |  |  |  |  | 10/30/80  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |
| JEFFREY S. ABRAMS, M.D.   |  |  | JOHNS HOPKINS HOSPITAL 601 N. BROADWAY   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |  |
| BURIAL  |  |  | 11-01-80   |  |  | LOUDON PARK  |  |  | BALTIMORE CITY MARYLAND   |  |  |
| 24. FUNERAL DIRECTOR  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |   |  |  |
| NAME ADDRESS  |  |  | 21229  |  |  |  |  |  |   |  |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.  |  |  |  |  |  | OCT 31 1980  |  |  | <u>Ruthy McCreedy</u>   |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND  |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                                   | 8 0 2 5 8 5 7  |                     |
|---|--|--|---|--|-----------------------------------|--|---------------------|
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  | MIDDLE  | LAST   | 2b. DATE OF DEATH                 |  | 2b. HOUR            |
| MILTON R. SMITH   |  |  |   |  | 10 28 80                          |  | 9 M                 |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | 7. IF UNDER 1 YEAR   |                     |
| MALE  | WHITE  | 09 13 1918   |   | 62 YRS.  |                                   | MONTHS DAYS HOURS MIN.   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |  |                     |
| Maryland  | U.S.A.   |  |   | BALTIMORE CITY MD.   |                                   |  |                     |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                     |
| BALTIMORE   | ST AGNES HOSPITAL  |  | Machine Operator  |  | Western Elec.                     |  |                     |
| 13a. STATE  |  |  |   | 13b. COUNTY  | 13c. CITY OR TOWN                 | 13d. INSIDE CITY LIMITS?                                       | 13e. STREET ADDRESS |
| Maryland  |  |  |   |  | Baltimore                         | YES <input type="checkbox"/> NO <input type="checkbox"/>       | 21223               |
| 14. FATHER'S NAME   |  |  |   | 15. MOTHER'S MAIDEN NAME   |                                   |  |                     |
| UNKNOWN   |  |  |   | Louise Emmiler   |                                   |  |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |   | 17. INFORMANT  |                                   | ADDRESS  |                     |
| yes   |  | W W 11   |   | Dorothy E. Smith   |                                   | Balto. Md. 21223   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                   |  |                     |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |  |                                   |  |                     |
| IMMEDIATE CAUSE (a)   |  |  |   | 4100   |                                   |  |                     |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   | Cardiogenic Shock.   |                                   |  |                     |
| (b)   |  |  |   |  |                                   |  |                     |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   | M.I.   |                                   |  |                     |
| (c)   |  |  |   |  |                                   |  |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |                                   |  |                     |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                     |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |  |                     |
|   |  | HOUR A.M. MONTH DAY YEAR   |   |  |                                   |  |                     |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION  |                                   |  |                     |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |   | STREET CITY OR TOWN COUNTY STATE   |                                   |  |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |                                   |  |                     |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |  |                     |
| DR. P. S. VERMA   |  | M.D.   |   | CCer Resident  |                                   |  |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |                                   |  |                     |
|   |  |  |   |  |                                   |  |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION  |                     |
| Burial  |  | 10-30-80   |   | Loudon Park Cemetery   |                                   | Baltimore  |                     |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   | STATE  |                     |
| NAME  |  | OCT 31 1980  |   | History McCreedy   |                                   | Maryland   |                     |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave.  |  |  |   |  |                                   |  |                     |

BALTIMORE CITY

ST AGNES HOSPITAL

BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 5 8

REG. NO.

|  |  |   |  |  |                              |  |  |  |  |  |  |
|--|--|---|--|--|------------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Roberta P. Smith</i>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10-6-80</i> |  | 2b. HOUR<br><i>5:35 A.M.</i> |  |  |  |  |  |  |
| 3 SEX<br><i>Female</i>   |  | 4 RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>4 24 1910</i>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>70</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Caroline Co., Va.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>      |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>ST AGNES HOSPITAL</i> |  |  |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Dept. of Ed.</i>                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>   |                              | 13d. INSIDE CITY LIMITS?<br><i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>3132 Normount Avenue</i>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>James Parker</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Leslie Ware</i>   |                              |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>214 40 6252</i>  |  | 17. INFORMANT ADDRESS<br><i>Mrs. Carolyn Allen 3678 Forest Hill Rd.</i>  |                              |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Disseminated Intravascular Coagulation</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Chronic granulocytic leukemia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>2051</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |                              |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Abcess R knee.</i>   |  |   |  |  |                              |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |                              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                              |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                              |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>September 1st 1980</i> , to <i>October 6th 1980</i> , that (I) (we) last saw the deceased alive on <i>October 6th 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |                              |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Bach T. Duong</i>   |  |   |  | DEGREE<br><i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                              |  |  | 22c. DATE SIGNED<br><i>10/6/80</i>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>BACH THUY DUONG</i>  |  |   |  | 22e. ADDRESS<br><i>St Agnes Hospital</i>   |                              |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>10/10/80</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Western Star</i>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Jas. A. Morton &amp; Sons</i>   |  |   |  | ADDRESS<br><i>1701 Laurens St.</i>   |                              |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 7 1980</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

MEDICAL CERTIFICATION

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1607 BP

BALTIMORE CITY

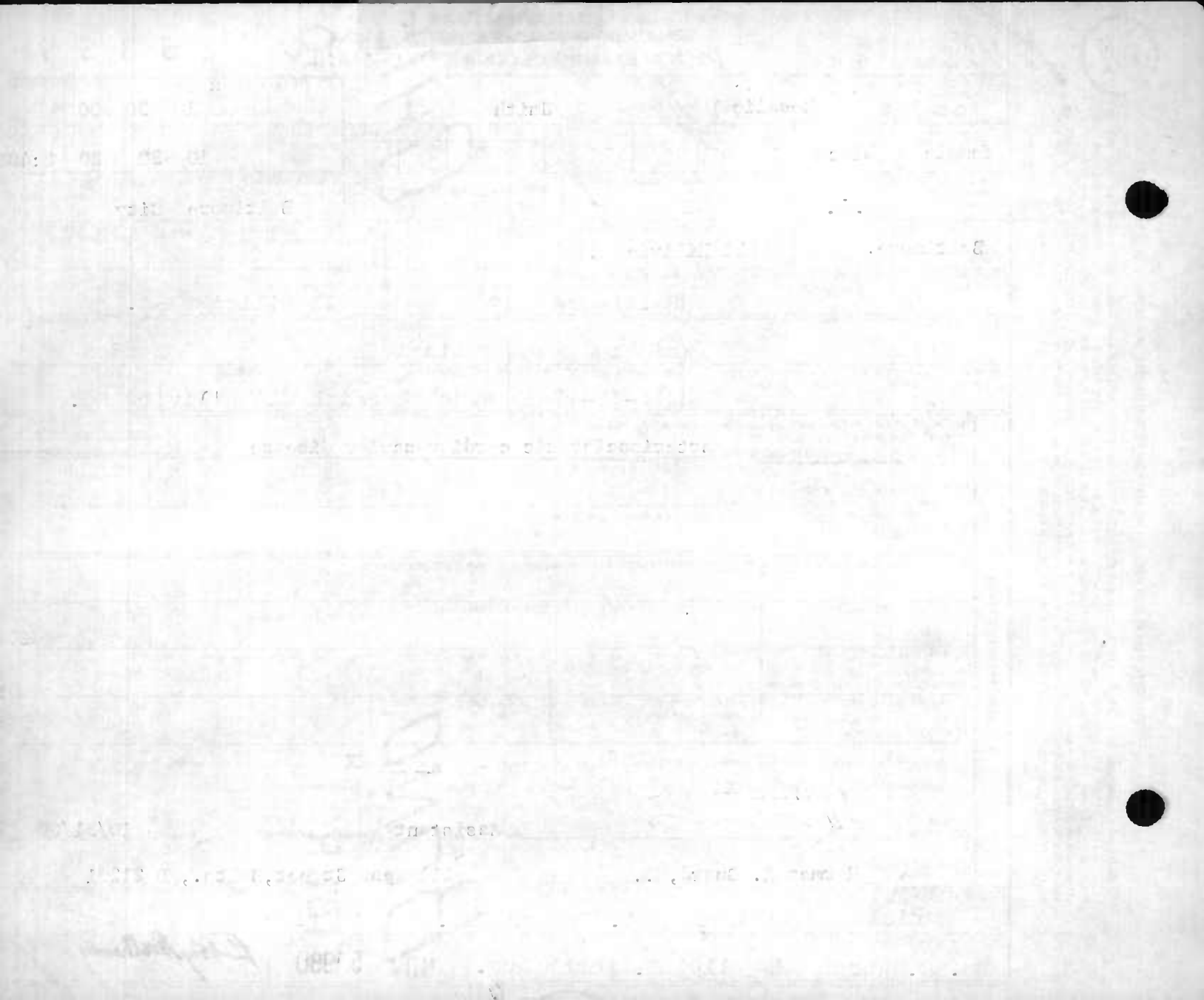
ST. JOHNS HOSPITAL

BALTIMORE

MD

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 0 2 5 8 5 9   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |
| DECEASED NAME (TYPE OR PRINT) <b>Rosalie ) Smith</b>   |  |  |  |  |  |  |  |  |  | KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>10 30 1980</b> |  |
| 3. SEX <b>female</b> 4. RACE <b>black</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>9 22, 04</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN   |  |  |  |  |  |  |  |  |  | 2b. HOUR <b>M</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 2c. DATE PRONOUNCED DEAD <b>10 30 1980</b> 2d. HOUR <b>2:40P</b>                     |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD  |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>621 Hillview Road</b>  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                        |  |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>621 Hillview Rd.</b>  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Eddie Wright</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lizzie Gordon</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>216-16-1541</b> 17. INFORMANT ADDRESS <b>Rudolph Smith 621 Hillview Rd.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Hormez R. Guard</b> TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER DATE SIGNED <b>10/31/80</b>  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b> ADDRESS <b>111 Penn Street, Balto., MD 21201</b>  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>11/4/80</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b> 25a. DATE REC'D. BY REGISTRAR <b>NOV 5 1980</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 5 8 6 0   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>William M Smith</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 24 80</b>   |  | 2b. HOUR<br><b>M</b>  |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 2 1915</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>65</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Philadelphia, Pa</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore, City</b> MD   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1116 S. East Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>counter-man</b>                                     |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Little-Tavern</b>  |  | 13a. STATE<br><b>M. ryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>William Smith</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Bertha Townsend</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1116 S. East Avenue</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215 05 1128</b>   |  | 17. INFORMANT ADDRESS<br><b>Mildred L. Smith 1116 S. East Avenue</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause pertaining for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of pharynx</b><br>1490<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>8/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CA Invert</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9</b> , 19 <b>80</b> , to <b>10</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>D.W. MacDonald</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/24/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D.W. MacDonald M.D.</b>  |  | 22e. ADDRESS<br><b>9 S. HIGHLAND AVE 21224</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/27/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Md</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Walter Dabrowski</b>   |  |  |  | ADDRESS<br><b>1005 Dundalk Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 31 1980</b>   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia A. ...</b>  |  |   |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 5 8 6 1   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>William R. Smoot  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 6 80   |  | 2b. HOUR<br>3:15p<br>M  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 16 17  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-  |  |
| 13a. STATE<br>MD  |  |  |  | 13b. COUNTY<br>Balt.  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS<br>3242 Kentucky Ave. 21213   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William R. Smoot Sr.   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Norma M. Griffin  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes  |  |  |  | 16b. SOCIAL SECURITY NO.<br>W.W.II 216-07-4692  |  | 17. INFORMANT ADDRESS<br>Norma M. Smoot 3242 Kentucky Ave.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary Edema<br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) Heart Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Sepsicemia<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Acute Renal Failure  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>9/19/8  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>(Oat cell Ca) L & L Resection  |  | 20a. AUTOPSY?<br>NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 2 FOR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 1 19 80, to 10/6/ 19 80, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Thomas E. Lipin MD  |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>10/7/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>T.E. Lipin   |  |  |  | 22e. ADDRESS<br>Mercy Hospital  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10-10-80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Balto. Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>John C. Miller Inc.  |  |  |  | ADDRESS<br>6415 Belair Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Ricky McCreedy  |  |

2633 BP



10001 41700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 370-1111.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |   |  |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH |   |  |  |                                | REG. NO. 80 25862  |                                 |   |  |  |
|--|--|---|--|---|--|---|--|--|--------------------------------|--|---------------------------------|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LILLIAN SMULSON   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 17 80   |   |  |  |                                | 2b. HOUR<br>9:30 AM  |                                 |   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>UNKNOWN  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  |  | 7. IF UNDER 1 YEAR MONTHS DAYS |  | 7b. IF UNDER 24 HRS. HOURS MIN. |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |                                |  |                                 |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3501 CLARKS LA., APT. B-2 |  |   |  |   |  |  |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>PROPRIETOR  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY<br>PHARMACY |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3501 CLARKS LA., APT. B-2                                     |                                |  |                                 |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MAYER LEVIN   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>HANNAH SALTZ  |  |   |  |  |                                |  |                                 |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT PROF. MARK SMULSON<br>3429 PORTER ST., NW - WASHINGTON, DC 20016  |  |   |  |  |                                |  |                                 |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>5939<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Insufficiency</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>15 years +</u> |  |   |  |   |  |   |  |  |                                |  |                                 |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  |  |   |  |   |  |   |  |  |                                |  |                                 |   |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                                |  |                                 |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |                                |  |                                 |   |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from <u>9/19/80</u> 19 <u>80</u> to <u>10/17</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/1</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |                                |  |                                 |   |  |  |
| 22a. SIGNATURE<br>Barnett Berman, M.D.   |  |   |  |   |  |   |  | DEGREE   |                                | 22b. DATE SIGNED<br>10-17-80   |                                 |   |  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BARNETT BERMAN, M.D.  |  |   |  |   |  |   |  | 22d. ADDRESS<br>641 PARK AVENUE BALTIMORE, MD, 21201                                 |                                |  |                                 |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>OCT. 19, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW FRIENDSHIP   |  |  |                                | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTIMORE MARYLAND  |                                 |   |  |  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  |   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>OCT 22 1980  |                                | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                                 |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 & 2 only be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8025863

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NANCY T. SNEAD   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 24 80                        |   |  | 2b. HOUR<br>4:55 PM   |  |  |  |  |
| 3. SEX<br>F   |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 17 22   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>United States  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>US  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                        |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>Maryland  |  |   |  |   | 13b. COUNTY<br>Baltimore                                     |   | 13c. CITY OR TOWN<br>Baltimore                                 |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John McCullough   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Carter |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-12-0769  |  | 17. INFORMANT<br>ADDRESS<br>Naaman Snead 13 N. Kossuth St.  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest - unknown</u><br>5850<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic Renal Failure</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |   |  |   |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> , 19 <u>80</u> , to <u>Oct. 24</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Oct. 24</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Kristen B. Raines MD  |  |   |  |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>10/24/80                                   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kristen B. Raines  |  |   |  |   | 22e. ADDRESS<br>University Hospital                          |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>10/30/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial Pk.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H  |  |   |  |   | ADDRESS<br>1101 E. North Ave.                                |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1980                   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

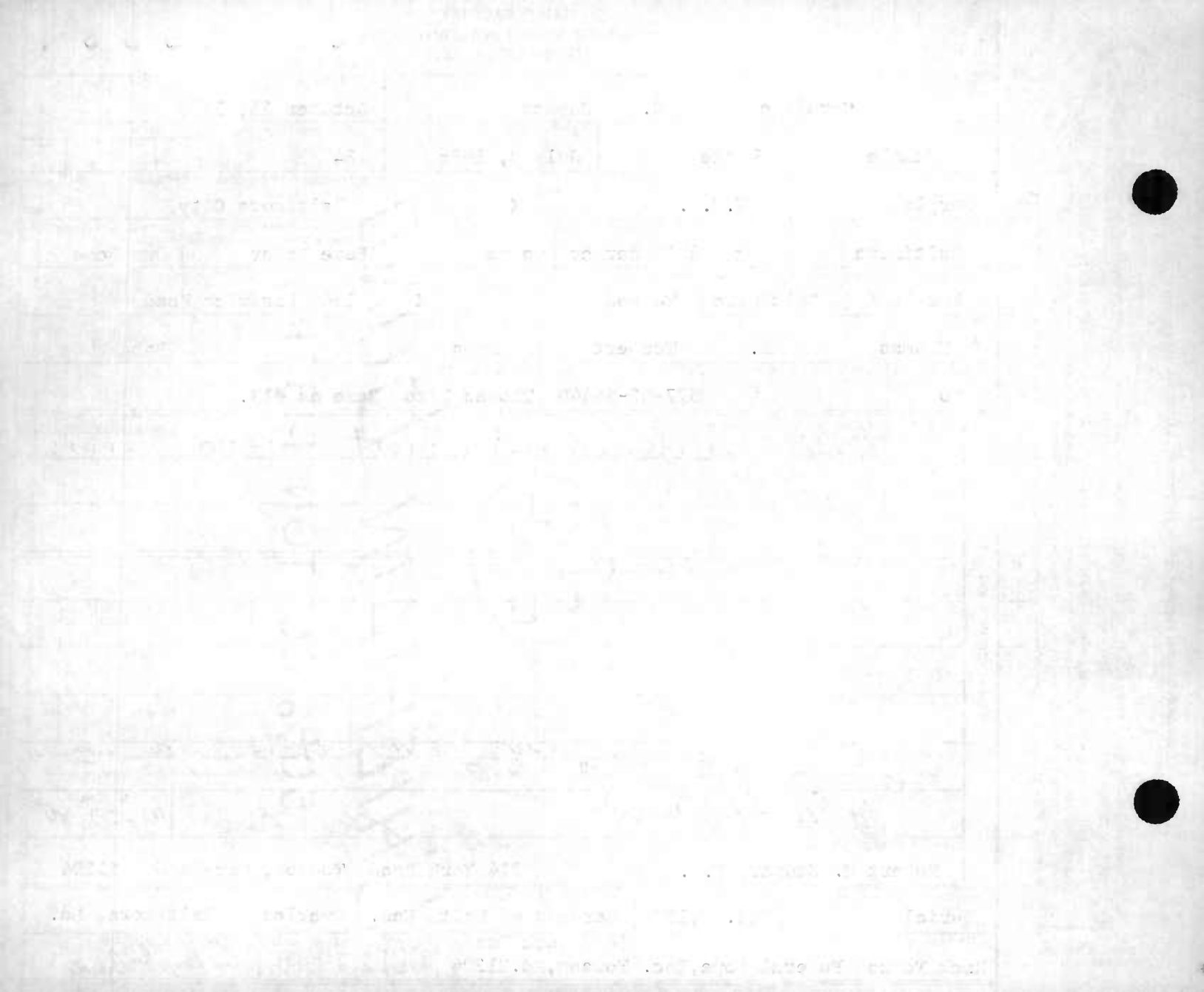
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_  
DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |  |  |   |  | 8 0 2 5 8 6 4  |  |  |  |
|--|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |   |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Caroline G. Snyder  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 25, 1980  |  |   |  | 2b. HOUR<br>M  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 8, 1896  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD   |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4326 Berger Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home Maker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Towson  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1640 Hardwick Road  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas A. Trabert  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Anna Hahn  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-02-5644D   |  | 17. INFORMANT<br>Thomas Vito  |  |  |  | ADDRESS<br>Same as #13.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>May</u> 19 <u>79</u> , to <u>Oct 25</u> 19 <u>80</u> , that (I) (we) lost saw the deceased at <u>Sept</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                         |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Robert E. Stoner</u>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10-27-80  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert E. Stoner, M.D.  |  |   |  |   |  | 22e. ADDRESS<br>714 York Road Towson, Maryland 21204   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Oct. 28, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Overlea Baltimore, Md.   |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc.   |  |   |  |   |  | 1050 York Road<br>ADDRESS<br>Towson, Md. 21204   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert E. Stoner</u>  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |        |   |  |  |                     |  |  |
|---|--|---|--------|---|--|--|---------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDWIN  |  | FIRST<br>M  | MIDDLE | LAST<br>SOLOMON   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>30 OCT 80 |  | 2b. HOUR<br>7:05 AM |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAUCASIAN  |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 8, 1893  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.   |                     | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                            |                     |  |  |
| 10. CITY OF DEATH<br>BALTIMORE MARYLAND   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |        |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WATCH MAKER      |                     | 12b. KIND OF BUSINESS OR INDUSTRY<br>JEWELRY   |  |
| 13a. STATE<br>MARYLAND  |  |   |        | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE   |                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ISAAC SOLOMON   |  |   |        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>FANNIE UNKNOWN   |  |  |                     |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>062-03-8404  |        | 17. INFORMANT<br>MRS. EVA SOLOMON<br>3010 ROMARIC CT., APT. F #21209  |  |  |                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |   |        |   |  |  |                     |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                     |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                     |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 30, 1980</u> to <u>NOV 2, 1980</u> , that (I) (we) lost saw the deceased alive on <u>30 OCT 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |        |   |  |  |                     |  |  |
| 22b. SIGNATURE<br><u>Frank W. Braxton</u> M   |  |   |        | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |                     | 22c. DATE SIGNED<br>13 OCT 80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>FRANK W. BRAXTON MD  |  |   |        | 22e. ADDRESS<br>SINAI HOSPITAL ER   |  |  |                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL   |  | 23b. DATE<br>NOV. 2, 1980   |        | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH JACOB  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>FINKSBURG BALTO. MD                    |                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO. MD 21215  |  |   |        | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1980   |  | 25b. REGISTRAR<br>[Signature]  |                     |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 6 6

REG. NO.

|  |  |  |  |   |  |   |  |                       |  |                  |  |            |  |
|--|--|--|--|---|--|---|--|-----------------------|--|------------------|--|------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY                   |  | YEAR             |  | 2b. HOUR   |  |
|  |  | Charles Sortino  |  | 10  |  | 9   |  | 80                    |  |                  |  | M          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR       |  | IF UNDER 24 HRS. |  |            |  |
| Male   |  | Cau.   |  | 2 23 01   |  | 79 YRS.   |  | MONTHS                |  | DAYS             |  | HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                       |  |                  |  |            |  |
| Italy  |  | U.S.A.   |  |   |  | Balto., City  |  |                       |  |                  |  | MD.        |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                       |  |                  |  |            |  |
| Balto  |  | 5620 Belair Rd.  |  | Barber  |  | Retired   |  |                       |  |                  |  |            |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                  |  |            |  |
| Md.  |  | -  |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5620 Belair Rd. 21206 |  |                  |  |            |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                       |  |                  |  |            |  |
| Joseph Sortino   |  | unknown  |  |   |  |   |  |                       |  |                  |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |   |  |                       |  |                  |  |            |  |
| no   |  | 217-12-7587  |  | Jennie Sortino  |  | 5620 Belair Rd. 21206   |  |                       |  |                  |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ABCD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>10 yrs</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |                       |  |                  |  |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |                       |  |                  |  |            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                       |  |                  |  |            |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                       |  |                  |  |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                       |  |                  |  |            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                       |  |                  |  |            |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>4-13</u> 19 <u>71</u> to <u>10-9</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9-18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                    |  |  |  |   |  |   |  |                       |  |                  |  |            |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |                       |  |                  |  |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 10-9-80   |  |                       |  |                  |  |            |  |
| Wyman K. Wong, M.D.  |  | 6801 Belair Rd. Baltimore, Md. 21206   |  |   |  |   |  |                       |  |                  |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |                       |  |                  |  |            |  |
| Burial   |  | 10-13-80   |  | Gardens of Faith  |  | Balto. Balto. Md.   |  |                       |  |                  |  |            |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                       |  |                  |  |            |  |
| John C. Miller Inc. 6415 Belair Rd.  |  | OCT 14 1980  |  | Rafael A. Brandy  |  |   |  |                       |  |                  |  |            |  |

0001 11 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 8 6 7

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |   |   |   |  |                            |  |   |  |
|--|--|---|---|---|---|--|----------------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LILLIE SPATH  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 20 80 |   |   | 2b. HOUR<br>2 <sup>20</sup> P.M.   |                            |  |   |  |
| 3. SEX<br>F  |  | 4. RACE<br>W  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7/26/85   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>95 YRS.   |                            | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.  |                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BALTO. CITY HOSP |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HSWE   |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>MD.  |  |   |   |   | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>ESSEX |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES BETHEY   |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARGARET UNK |  |                            |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>214 74 6611   |   | 17. INFORMANT<br>HENRY SPATH  |   | ADDRESS<br>ABOVE   |                            |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ACUTE HEMISPHERIC CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASEMI</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |   |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>ONE<br>WEEK<br>YEARS.   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>CONGESTIVE HEART FAILURE</u>   |  |   |   |   |   |  |                            |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |                            |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                            |  |   |  |
| 22a. I certify that (b) (this hospital) attended the deceased from <u>10/3</u> 19 <u>80</u> to <u>10/20</u> 19 <u>80</u> , that (1) (we) saw the deceased and (2) (we) (did not) view the body after death.  |  |   |   |   |   |  |                            |  |   |  |
| 22b. SIGNATURE<br><u>Bradley S Bender</u>  |  |   |   | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                            | 22c. DATE SIGNED<br>10/20/80   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRADLEY S BENDER  |  |   |   | 22e. ADDRESS<br>BALTO CITY HOSPITAL   |   |  |                            |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>10/22/80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD  |                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. L. CONNELLY   |  |   |   | ADDRESS<br>300 MACE   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1980   |                            | 25b. REGISTRAR'S SIGNATURE<br><u>Henry Mace</u>  |   |  |

TO: Mr. J. W. [illegible]  
FROM: Mr. [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[illegible text follows]

[illegible text follows]

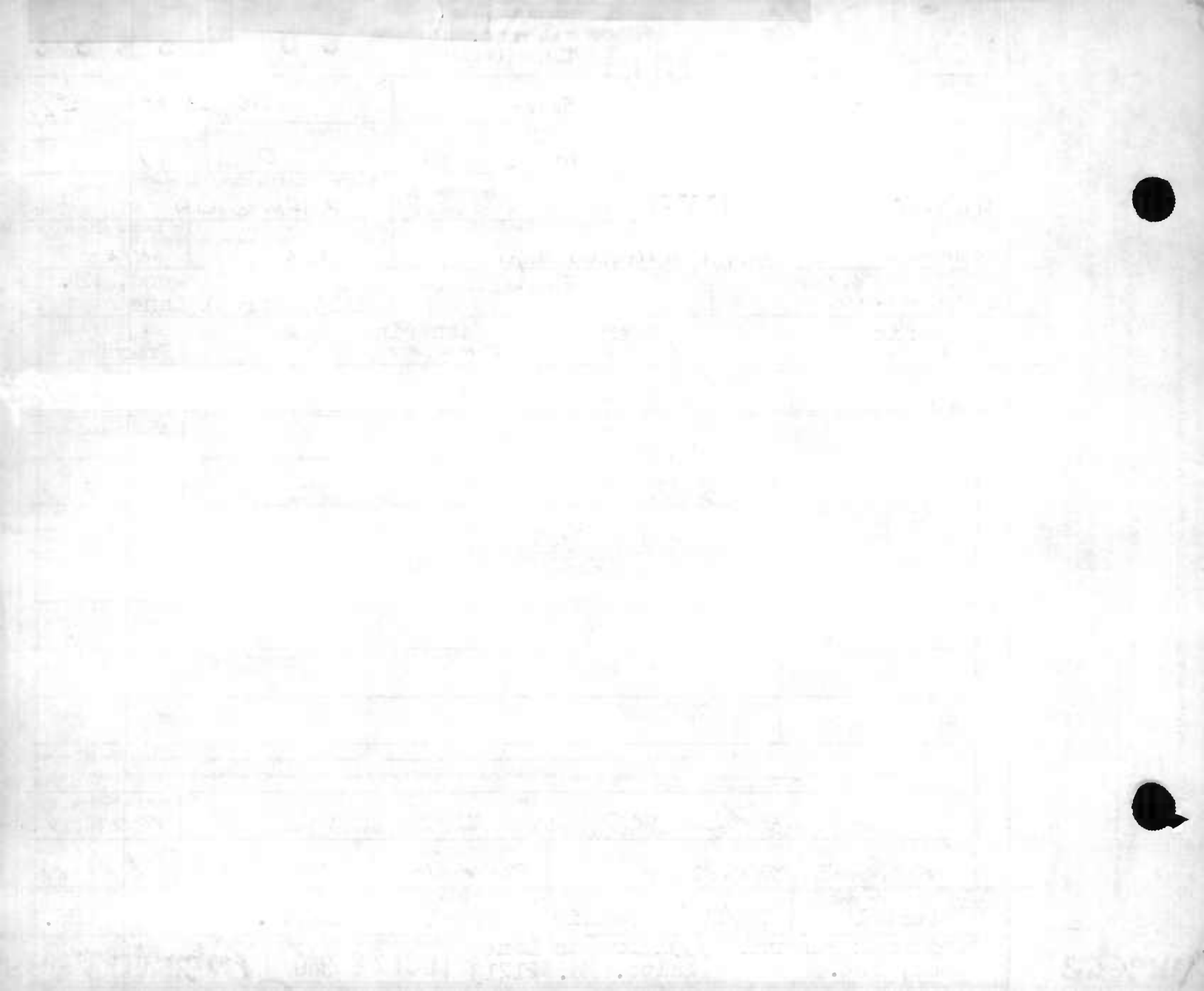
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 80 25868  |  | REG. NO.   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL "Baby Girl" SPICER</b>  |  | LAST <b>Spicer</b>  |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>23</b> YEAR <b>80</b>   |  | 2b. HOUR <b>1259</b> AM  |  |  |  |
| 3. SEX <b>female</b>  |  | 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH MONTH <b>10</b> DAY <b>21</b> YEAR <b>80</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>0</b> YRS   |  | IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b> IF UNDER 24 HRS HOURS <b>1</b> MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md. Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A. United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University of Maryland Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>not applicable</b>  |  | 13b. COUNTY <b>HARF</b>   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS <b>Edgewood, Md. 2113 Carroll Lane</b>                       |  |
| 14. FATHER'S NAME <b>Donnie</b> MIDDLE <b>SPICER</b>  |  | 15. MOTHER'S MAIDEN NAME <b>Catherine</b> MIDDLE <b>Foard</b> LAST <b>Foard</b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO <b>-</b>  |  | 17. INFORMANT ADDRESS <b>Donnie Spicer (father) same address</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>apoplexy</b>  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple cerebral infarction</b>  |  |   |  |  |  |  |  | 1 day  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Birth Asphyxia</b>  |  |   |  |  |  |  |  | 1 day  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>EDWARD MARGOLIES, MD, MPH</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>10/23/80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD MARGOLIES</b>   |  | 22e. ADDRESS <b>Pediatrics University Hospital Baltimore</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>10/27/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BelAir Memorial</b>  |  | 23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>  |  |  |  |
| 24. FUNERAL DIRECTOR'S NAME <b>Seidman's Funeral Home, Inc.</b>   |  | 3331 Brehms Lane Balto. Md. 21213   |  | 25a. DATE REC'D BY REGISTRAR <b>OCT 28 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>D. J. Brady</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8-0 25869   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) JOHN F. SPITES  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 10-13-80   |  |   |  |
| 3 SEX Male   |  | 4 RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR July 1, 1899  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.  |  |
| 10 CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hamilton Nursing Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman   |  | 12b. KIND OF BUSINESS OR INDUSTRY Balto. City   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS Broadview Apartments  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hahn  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes  |  | 16b. SOCIAL SECURITY NO WW I 220 44 4224   |  | 17. INFORMANT ADDRESS Mrs. Mary Alice Spites Same   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive CVA with rt. hemiparesis 4029   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H.A.S.C.V.D., old CVA with 5 days   |  |  |  |   |  |   |  |
| (c) left hemiparesis   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (his) hospital attended the deceased from 7/11 19 80, to 10/13 19 80, that (I) (we) lost saw the deceased alive on 10/10 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE J. Fromm, MD  |  |  |  | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c. DATE SIGNED 10/13/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.W. FROMM, MD   |  |  |  | 22e. ADDRESS 8014 Old Harford Rd., Balto Md   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  | 23b. DATE 10/15/80   |  | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. 21234  |  |
| 24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 06114 1980  |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |

4605 York Road, Baltimore, Md. 21215  
 Henry W. Jenkins & Sons Co.  
 10135 80th Ave, Oak Lawn, Ill.  
 Baltimore, Md.  
 10135 80th Ave, Oak Lawn, Ill.

10-15-50

Yes WW I 220 44 4224 Mrs. Mary Alice Smith Baltimore

Unknown

MARY

Hahn

Maryland Baltimore x Groceries Apartment Baltimore City

Baltimore Hamilton Nursing Home Policeman Baltimore City

10-15-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. 8 0 2 5 8 7 0          |  |  |  |
|---|--|--|--|---|--|---|--|--|--|---------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JOHN EDWARD SPRINKEL   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 31 1980  |  |  |  | 2b. HOUR<br>10:52 <sup>AM</sup> |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 20 27  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>✓   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |  |                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC, LOCH RAVEN, BALTIMORE, MD |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CARPENTER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>KNOTT   |  |                                 |  |  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>←   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>835 WELLINGTON STREET 21211   |  |                                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN W. SPRINKEL  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RUTH YOUNGER   |  |   |  |  |  |                                 |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II   |  | 17. INFORMANT<br>WIFE   |  | ADDRESS   |  |  |  |                                 |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>1919<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GLIOMA, POSTERIOR FOSSA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |   |  |  |  |                                 |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>NOT APPLICABLE</u>   |  |  |  |   |  |   |  |  |  |                                 |  |  |  |
| 19a. DATE OF OPERATION<br>✓   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>✓  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>✓   |  |   |  |  |  |                                 |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>✓  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>✓  |  |   |  |  |  |                                 |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>OCTOBER 10</u> , 19 <u>80</u> , to <u>OCTOBER 31</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>OCTOBER 31</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death. |  |  |  |   |  |   |  |  |  |                                 |  |  |  |
| 22b. SIGNATURE<br><u>Woroner</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>10/31/80   |  |                                 |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Woroner</u>   |  |  |  |   |  | 22e. ADDRESS<br>VAMC, LOCH RAVEN, BALTIMORE, MD. 21218  |  |  |  |                                 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11/4/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LAKEVIEW  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CARROLL CO., MD.  |  |  |  |                                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Paul E. Chenoweth</u>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 6 1980   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry K. Brady</u>  |  |                                 |  |  |  |



*[Faint, mostly illegible handwritten text covering the majority of the page. Some words like "received" and "Jan 10" are visible in the header area.]*



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |
| 2. DECEASED NAME FIRST MIDDLE LAST<br>GERALD J. STAKE  |  |  |  |  |  |  |  |  |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br>10/31/80   |  |  |  |  |  |  |  |  |  |
| 2b. HOUR<br>6:55 A.M.  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male   |  |  |  |  |  |  |  |  |  |
| 4. RACE<br>White   |  |  |  |  |  |  |  |  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>3 19 05   |  |  |  |  |  |  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  |  |  |  |  |  |  |  |  |
| 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>FRANKLIN Co, PA   |  |  |  |  |  |  |  |  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |  |  |  |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE, MD City MD.   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  |  |  |  |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Good Samaritan Hospital   |  |  |  |  |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auto Mechanic   |  |  |  |  |  |  |  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |
| 13a. STATE<br>Md.  |  |  |  |  |  |  |  |  |  |
| 13b. CITY OR TOWN<br>Balto.  |  |  |  |  |  |  |  |  |  |
| 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 13d. STREET ADDRESS<br>6537 Corkley Rd.  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Wesley P. Stake   |  |  |  |  |  |  |  |  |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CARRIE Carbaugh  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  |  |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>188-10-0240  |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT ADDRESS<br>MRS. GERALD J. STAKE 6537 CORKLEY RD. BALTIMORE MD. 21237   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC Arrest</u><br>1991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Metastatic carcinoma</u><br>(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |  |  |  |  |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  |  |  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/03</u> 19 <u>80</u> , to <u>10/31</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE DEGREE<br><u>Antonio S. Cassanego</u>   |  |  |  |  |  |  |  |  |  |
| 22c. DATE SIGNED<br>10/31/1980   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Antonio Serrano Cassanego   |  |  |  |  |  |  |  |  |  |
| 22e. ADDRESS<br>5601 Loch Raven Blvd. Balto.   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  |  |  |  |  |  |  |
| 23b. DATE<br>Nov. 3, 1980  |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>LINCOLN  |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>CHAMBERSBURG, FRANKLIN Co. PA.  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>EITNE FUNERAL HOME, REISTERSTOWN 21136   |  |  |  |  |  |  |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 7 1980  |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |  |  |  |  |  |  |

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Items 192 & 19b G549 11/12/80 da STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

FOR  
 1- STATE  
 REGISTRAR

REG. NO. 8 0 2 5 8 7 3

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CAROLYN Jean STERN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 19 80</b><br>HOUR<br><b>11 01 AM</b>               |  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 24 - 1939</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>41</b><br>YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Madison, Wisc.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Librarian</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Int'l Money Fund</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>D.C.</b>  |  |   | 13b. COUNTY<br><b>Washington</b>  |  |  |
| 13c. CITY OR TOWN<br><b>Washington</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><b>2401 "H" St.</b>   |  |   | 13f. STREET ADDRESS<br><b>2401 "H" St.</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Stern, Jr.</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helen Jucken</b>                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>N/A</b>  |  |  |
| 17. INFORMANT<br><b>Wm. Stern, Jr. (father)</b>  |  |   | ADDRESS<br><b>642 Chatham Terrace<br/>Madison, Wisc.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br><b>2050</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GRAFT VS HOST DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>BONE MARROW TRANSPLANT</b>   |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>ACUTE MYELOGENOUS LEUKEMIA</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>9/3/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Acute Myelogenous leukemia</b>   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |  |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>8/22/80</b> , 19 <b>80</b> , to <b>10/19/80</b> , 19 <b>80</b> , that (we) lost<br>saw the deceased alive on <b>10/19/80</b> , 19 <b>80</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Wyle L. Sensenbrenner M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>10/19/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WYLE L. SENSENBRENNER</b>  |  | 22e. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/23/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cemetery</b>                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Madison Dane Wisc.</b>  |  | 23e. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Madison Dane Wisc.</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Fleming Funeral Service - Benson, Md.</b>   |  | ADDRESS<br><b>21018</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1980</b>                                  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Barney McCreedy</b>   |  | 25c. REGISTRAR'S SIGNATURE<br><b>Barney McCreedy</b>  |   |  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 7 4

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |   |  |   |   |  |   |  |
|--|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles B. Stevenson</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-4-80</b>                  |   |  | 2b. HOUR<br><b>1:05 AM</b>  |   |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>Negroid</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-30-13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                         |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. City</b> MD.            |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE</b>   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-09-4074</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Harry Stevenson 3915 Barrington</b>   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1991 Probable Malignant Ds.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/4/80</b> to <b>10-4-80</b> , that (I) (we) lost saw the deceased alive on <b>10/4/80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Maurence A. Allen, Jr. M.D.</b>   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>10-4-80</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M.A. Allen, Jr.</b>  |  |  |  |   | 22e. ADDRESS<br><b>Provident Hosp. Inc.</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>10/11/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. PK.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Vernon Bailey</b>   |  |  |  |   | ADDRESS<br><b>1348 Calhoun St.</b>   |   | 25. DATE REC'D BY REGISTRAR<br><b>OCT 10 1980</b>               |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Vital Records with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10/11/1911  
Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.  
The same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. H. [Name]  
[Title]  
[Address]



21-

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

25875

|   |  |  |  |   |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Bryant</b>  |  | FIRST  |  | MIDDLE  |  | LAST<br><b>Stewart</b>  |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR |  | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 7 55</b>   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>25 YRS.</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore City Hospital</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                   |  | 13e. STREET ADDRESS<br><b>708 E. Preston St.</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alvin Stewart</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mabel Henderson</b>   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mabel Stewart 708 E. Preston St.</b>   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stab Wound of Abdomen</b><br><b>966-</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR <b>8:30</b> MONTH <b>10</b> DAY <b>10</b> YEAR <b>80</b><br>P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject stabbed</b>                           |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br><b>street</b>   |  | 21f. LOCATION<br>STREET <b>2000 Block</b> CITY OR TOWN <b>Baltimore</b> COUNTY STATE<br><b>of E. Jefferson St., Baltimore Md.</b> |  |   |  |   |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>   |  |  |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | DATE SIGNED <b>10/11/80</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |  |  |  | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>10/15/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY STATE<br><b>MD</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>   |  |  |  |   |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McBrady</b>                                 |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or exhumation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another trauma event, the medicolegal examiner must be notified at once.

BP

DHMM-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 8 0 2 5 8 7 6   |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AKA FIRST Louise T. Stokes</b><br><b>TAHLISHA Louise STOKES</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCT. 5, 1980</b>   |  | 2b. HOUR<br><b>4:20am</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 21, 1980</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. <b>7</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Delaware</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Del.</b> 13b. CITY OR TOWN <b>New Castle Newark</b>  |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>44 Fairway Road</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dwight Brokenbrough</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary L. Stokes</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br>ADDRESS <b>Newark, Del. 1971</b><br><b>Dwight Brokenbrough 44 Fairway Rd.</b>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC/RESPIRATORY ARREST</b><br><b>7429</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HEPATIC ENCEPHALOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>HEPATIC ENCEPHALOPATHY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MINUTES</b><br><b>4 DAYS</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>RENAL FAILURE</b>  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/4 12:00pm</b> , 19 <b>80</b> , to <b>10/5 4:20am</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10/5 - 4:20am</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Barbara Fush</b>   |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/5/80</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BARBARA FUSH</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/9/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Newark Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Newark, New Castle, Del.</b>  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert T. Jones Newark, Del</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 9 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert T. Jones</b>   |  |   |  |

MEDICAL CERTIFICATION



19

OCT 1 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 7 7  
REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anthony J. Stover (Piezonki)  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 11, 1980 |  |  | 2b. HOUR<br>7:00 A.M.   |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>May 26, 1916  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore, Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                      |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3513 E. Northern Parkway, Apt B |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspector                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |   |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Apt. B 21206<br>3513 E. Northern Parkway  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Piezonki  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Friedel   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-07-1664   |  | 17 INFORMANT ADDRESS<br>Elizabeth Mae Stover (same as line 13)   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Carcinoma of the lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>6 months</u> |  |  |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on <u>Mid September</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Larry Waterbury, M.D.</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c. DATE SIGNED<br>10/11/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Larry Waterbury, M.D.  |  |  |  | 22e. ADDRESS<br>801 Hillen Rd. 21204   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/14/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck Funeral Home, Inc.   |  |  |  | ADDRESS<br>Dundalk, Md. 21222  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 14 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Larry Waterbury</u>   |  |

100-100000 (100000)

May 24, 1916

Bellevue City

Bellevue City

Bellevue City

Bellevue City

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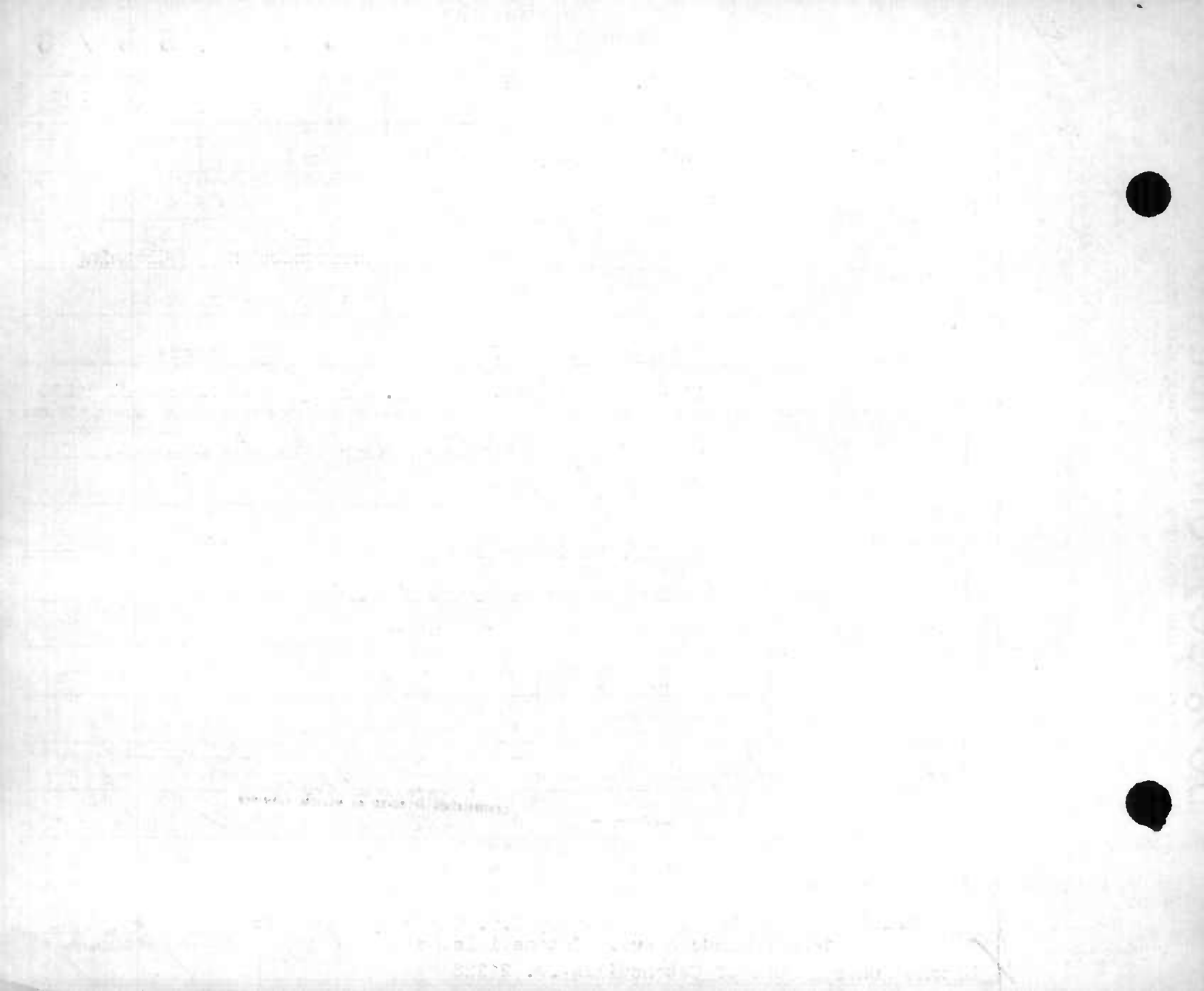
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 0 2 5 8 7 8<br>REG. NO.   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST JESSIE MIDDLE L. LAST STRONG<br>JESSIE L. STRONG   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 22 80  |  |   |  | 2b. HOUR<br>8 <sup>15</sup> am  |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 3, 1899  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTH BALTIMORE GENERAL H. |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR WORKING LIFE)<br>Retired<br>XXXXXXXXXXXX  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Cleaning   |  |
| 13a. STATE<br>MD.  |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |  | 13e. STREET ADDRESS<br>1946 MAISEL ST.          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Daniel Bearinger   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie Moore  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no   |  |   |  | 16b. SOCIAL SECURITY NO.<br>217-01-0626A  |  | 17. INFORMANT ADDRESS<br>Mr. Jesse E. Strong, 1946 Maisel St 21230        |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary atelectasis and bronchopneumonia<br>8842<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Aspiration<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Fracture of femur<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Generalized atherosclerosis + cardiomegaly |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION<br>10/15/80   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>FX FEMUR AND FX HUMERUS   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 10 04 1980  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>Pt fell down from wheel chair   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>home  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1946 MAISEL ST BALTIMORE MD.   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/04/80, 19____, to 10/22/80, 19____, that (I) (we) lost<br>saw the deceased alive on 10/22/80, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>J. Caldwell  |  |   |  | DEGREE: <u>Physician</u><br>CERTIFICATION APPROVED BY MEDICAL EXAMINER<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>10/22/80  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JORGE E. ULDERMAN   |  |   |  | 22e. ADDRESS<br>SOUTH BALTIMORE GENERAL HOSPITAL  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/25/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary M.E. Cemetery   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Bel Air Maryland  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Witzke Funeral Home of Catonsville P.A. 21228  |  |   |  | 24. RATE PER DAY BY REG. NO. 25b. REGISTRAR'S SIGNATURE<br>OCT 24 1980  |  |   |  |   |  |   |  |





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

25879

REG. NO.

|   |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
|---|--|---|--|--|--------------------------------------|---|---------------------|--|--------------------|--|------|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |                                      | LAST  |                     | 2a. DATE OF DEATH  |                    | MONTH  | DAY  | 1980                       | 2b. HOUR                                     |  |
| HELEN   |  | STRZEGOWSKI   |  | OCTOBER  |                                      | 11, XX  |                     | 0:45A.M.   |                    |  |      |                            |  |  |
| 3. SEX  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |   | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS    |  |      |                            |  |  |
| FEMALE  | WHITE  |   | MARCH 5 1918   |  | 62                                   |   | YRS.                |  | MONTHS             |  | DAYS |                            | HOURS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                     |  |                    |  |      |                            |  |  |
| MARYLAND  | U.S.A.   |   |  |  | BALTIMORE CITY                       |   | MD.                 |  |                    |  |      |                            |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY    |   |                     |  |                    |  |      |                            |  |  |
| BALTIMORE   | CHURCH HOSPITAL  |   | HOMEMAKER  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?             |   | 13e. STREET ADDRESS |  |                    |  |      |                            |  |  |
| MD.   | BALTIMORE  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 216 S. CHESTER ST.                   |   |                     |  |                    |  |      |                            |  |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.             |   | 17. INFORMANT       |  | ADDRESS            |  |      |                            |  |  |
| STEVE CLINOWIECKI   | MARTHA   |   | NO   |  | 212 09 7482                          |   | EDWARD STRZEGOWSKI  |  | 216 S. CHESTER ST. |  |      |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |                                      |   |                     |  |                    |  |      |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK   |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| 410 -   |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| (b) MYOCARDIAL INFARCTION   |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE   |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |                                      | 20a. AUTOPSY?   |                     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                    |  |      |                            |  |  |
|   |  |   |  |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                    |  |      |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                      |   |                     |  |                    |  |      |                            |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
|   |  | P.M. 19   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |                                      | CITY OR TOWN  |                     | COUNTY   |                    | STATE  |      |                            |  |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| 22a. I certify that (I) this hospital attended the deceased from SEPTEMBER 11, 1980, to OCTOBER 11, 1980, that (I) we lost<br>saw the deceased alive on OCTOBER 11, 1980, and that in (my) own opinion death occurred on the date and hour and from the causes stated<br>above, (I) we did (did not) view the body after death. |  |   |  |  |                                      |   |                     |  |                    |  |      |                            |  |  |
| 22b. SIGNATURE  |  |   |  |  |                                      |   |                     |  |                    | DEGREE   |      | 22c. DATE SIGNED           |  |  |
| A. F. Nazemi, M.D.  |  |   |  |  |                                      |   |                     |  |                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |      | OCTOBER 11, 1980           |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |  |                                      |   |                     |  |                    | 22e. ADDRESS   |      |                            |  |  |
| A. F. NAZEMI, M.D.  |  |   |  |  |                                      |   |                     |  |                    | CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231  |      |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (a) (c) (f)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |                                      | 23d. LOCATION   |                     | CITY OR TOWN   |                    | COUNTY   |      | STATE                      |  |  |
| BURIAL  |  | 10/14/1980  |  | SACRED HEART OF JESUS  |                                      | BALTIMORE   |                     | MD   |                    |  |      |                            |  |  |
| 24. FUNERAL DIRECTOR  |  |   |  |  |                                      |   |                     |  |                    | 25a. DATE REC'D. BY REGISTRAR  |      | 25b. REGISTRAR'S SIGNATURE |  |  |
| RAYMOND L. KACZOROWSKI  |  |   |  |  |                                      |   |                     |  |                    | OCT 15 1980  |      | R. J. McHenry              |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*Handwritten signature*

0801 21 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 0 2 5 8 8 0   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR  |  |
| Thomas   |  | Sudler  |  | 9 16 80   |  | 8:50 P.M.   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | Negro   |  | 7 11 92   |  | 88 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Md.  |  | U. S. A.  |  |   |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |  | Pleasant Manor Nursing Home   |  | unknown   |  | unknown   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.  |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS   |  |   |  |
| First MIDDLE LAST  |  | First MIDDLE LAST   |  | 1571 Richland St.   |  |   |  |
| UNKNOWN  |  | UNKNOWN   |  |   |  |   |  |
| 16a. CAST OR BORN IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |
| Yes  |  | WW-I  |  | 212-14-0820   |  | Pleasant Manor Nursing Home<br>4615 Park Heights Ave.               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>carcinoma - (small intestine)</u><br>1529<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>w/ mesenteric metastasis</u><br>3 mos<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>80</u> , to <u>9-16</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9-16</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE   |  |   |  | DEGREE  |  | 22c. DATE SIGNED  |  |
| Jaime Punzalan   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS  |  |   |  |
| Jaime M. Punzalan, M. D.   |  |   |  | 5214 Harford Rd.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| Cremation  |  | 9/23/80   |  | Westview Mem Pk   |  | Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR NAME  |  |   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Law Funeral Home, 4611 Park Heights Ave  |  |   |  | OCT 22 1980   |  | [Signature]   |  |

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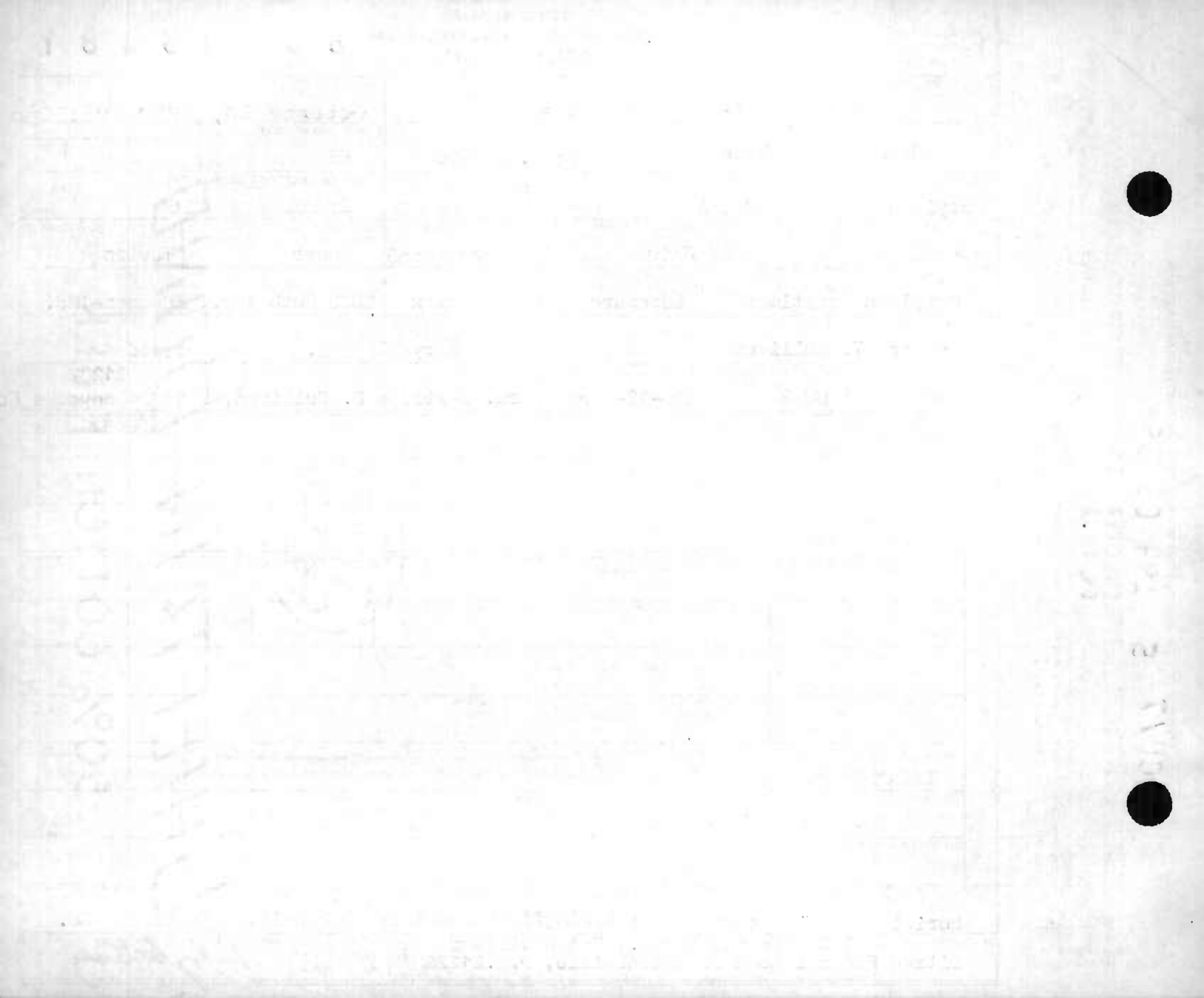
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |  |  | 8 0 2 5 8 8 1<br>REG. NO.  |  |  |  |                             |  |
|---|--|--|--|---|---|--|--|--|--|--|--|--|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Earl F. Sullivan</b> |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 24, 1980</b>  |  |  |  | 2b. HOUR<br><b>03:10 PM</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 9, 1925</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.                              |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |  |  |                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD               |  |  |  |  |  |  |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  |   |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tavern</b>   |  |  |  |                             |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a. STATE<br><b>Maryland</b>   |   |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Edgemere</b>   |  |  |  |                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward T. Sullivan</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary E. Norwood</b>   |   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW 2</b>   |   | 17. INFORMANT<br><b>Mrs. Gertrude D. Sullivan</b>                              |  |  |  | ADDRESS<br><b>21207 Johnnycake Rd</b>  |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>intracerebral hld.</b><br>4301<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |                             |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |  |  |                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>16 Oct 1980</b> , to <b>24 Oct 1980</b> , that (I) (we) lost saw the deceased alive on <b>24 Oct 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |  |  |  |  |                             |  |
| 22b. SIGNATURE<br><b>G B Vogelsang MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>24 Oct 80</b>   |  |  |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>G B Vogelsang MD</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital Baltimore</b>   |   |  |  |  |  |  |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>10/28/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Springfield Cemetery</b>              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville, Carroll Md.</b>   |  |  |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>1630 Edmondson Ave., Catonsville Md</b>  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 27 1980</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. H. Kelly</b>   |  |  |  |  |  |                             |  |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
|--|--|--|--|---|--|---|--|---|--|------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN<br>OF DEATH  |  | ESTI-<br>MATED   |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR |  |
| Paul   |  | H.   |  | Summers   |  |   |  | 2a. DATE KNOWN<br>OF DEATH  |  | ESTI-<br>MATED   |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR |  |
| male   |  | white  |  | June 22, 1921   |  | 59 YRS.   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS. |  | MONTH |  | DAY |  | YEAR |  | 2b. HOUR |  |
| 12. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                  |  |       |  |     |  |      |  |          |  |
| Maryland   |  | U.S.   |  | WIDOWED   |  | DIVORCED  |  | Baltimore City  |  |                  |  |       |  |     |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)              |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| Baltimore  |  | University Hospital  |  | Farmer  |  |   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                  |  |       |  |     |  |      |  |          |  |
| Maryland   |  | Frederick  |  | Frederick   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 5729 Old National Pike  |  |                  |  |       |  |     |  |      |  |          |  |
| 14. FATHER'S NAME  |  | MIDDLE   |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | FIRST   |  | MIDDLE           |  | LAST  |  |     |  |      |  |          |  |
| John W. B. Summers   |  |  |  |   |  | Grace Baker   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| No   |  | 215-14-1747  |  | John A. Summers   |  | 13 E.   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| 9190   |  | Cranio-cerebral injury   |  |   |  |   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last,   |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
|  |  | (c)  |  |   |  |   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | HEAD ONLY   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |       |  |     |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>2:30 10-17-80  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | Decedent struck by farm equipment.                                  |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>field                                    |  | 21f. LOCATION<br>STREET<br>Butter Fly Lane, Frederick, Frederick Md.          |  |   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)<br>Assistant   |  | DATE SIGNED   |  | 10-22-80  |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| ACTUAL<br>SIGNATURE  |  | EXAMINER'S NAME<br>(TYPE OR PRINT)   |  | ADDRESS   |  | 111 Penn St.  |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| Virginia L. Dolan  |  | Virginia L. Dolan, M.D.  |  |   |  |   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN                                       |  | COUNTY  |  | STATE            |  |       |  |     |  |      |  |          |  |
| Burial   |  | 10/24/80   |  | Mt. Olivet  |  | Frederick   |  | Frederick   |  | Md.              |  |       |  |     |  |      |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | REGISTRAR'S SIGNATURE   |  |   |  |                  |  |       |  |     |  |      |  |          |  |
| Dailey Funeral Home  |  | 1201 N. Market<br>Frederick, Md.   |  | OCT 28 1980   |  | [Signature]   |  |   |  |                  |  |       |  |     |  |      |  |          |  |

1. The first of these is the fact that the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |                              |  |   |                                |   |                                      |   |  | 8 0 2 5 8 8 3  |  |                                   |                 |   |  |                     |  |
|--|--|------------------------------|--|---|--------------------------------|---|--------------------------------------|---|--|--|--|-----------------------------------|-----------------|---|--|---------------------|--|
| 1. FOR STATE REGISTRAR   |  |                              |  |   | REG. NO.                       |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |                              |  |   | 2a. DATE OF DEATH              |   |                                      |   |  | 2b. HOUR   |  |                                   |                 |   |  |                     |  |
| Nellie H Swank   |  |                              |  |   | MONTH DAY YEAR<br>10 8 80      |   |                                      |   |  | 8 1/2 M  |  |                                   |                 |   |  |                     |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                |   | 6. AGE (IN YEARS LAST BIRTHDAY)      |   |  | IF UNDER 1 YEAR  |  |                                   | IF UNDER 24 HRS |   |  |                     |  |
| Female   |  | White                        |  | MONTH DAY YEAR<br>1 14 1894   |                                |   | 86 YRS.                              |   |  | MONTHS DAYS HOURS MIN.   |  |                                   |                 |   |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |  |  |  |                                   |                 |   |  |                     |  |
| Md.  |  | USA                          |  |   |                                |   | Baltimore City MD.                   |   |  |  |  |                                   |                 |   |  |                     |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                                |   |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                 |   |  |                     |  |
| Baltimore  |  |                              |  | Mercy Hospital  |                                |   |                                      | Homemaker   |  |  |  |                                   |                 |   |  |                     |  |
| 13a. STATE   |  |                              |  |   |                                |   |                                      |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                 |                 | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |
| Md.  |  |                              |  |   |                                |   |                                      |   |  |  |  | Baltimore                         |                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 700 N. Charles St.  |  |
| 14. FATHER'S NAME  |  |                              |  |   | 15. MOTHER'S MAIDEN NAME       |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| FIRST MIDDLE LAST<br>WM J McCoubrey  |  |                              |  |   | FIRST MIDDLE LAST<br>Elizabeth |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |                              |  | 16b. SOCIAL SECURITY NO.  |                                | 17. INFORMANT   |                                      |   |  | ADDRESS  |  |                                   |                 |   |  |                     |  |
| no   |  |                              |  | 220 18 7780   |                                | Thaddeus W. Swank   |                                      |   |  | Same   |  |                                   |                 |   |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |                              |  |   |                                |   |                                      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |                                   |                 |   |  |                     |  |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>  |  |                              |  |   |                                |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable arrhythmia</u>   |  |                              |  |   |                                |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                              |  |   |                                |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |                              |  |   |                                |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |                              |  |   |                                |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                |   |                                      | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                                   |                 |   |  |                     |  |
|  |  |                              |  |   |                                |   |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                                   |                 |   |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |                              |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/8</u> , 19 <u>80</u> , to <u>10/8</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10/8</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |   |                                |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| 22b. SIGNATURE   |  |                              |  | DEGREE  |                                |   |                                      | 22c. DATE SIGNED  |  |  |  |                                   |                 |   |  |                     |  |
| <u>John M. Gaber</u>   |  |                              |  | MD  |                                |   |                                      | 10/8/80   |  |  |  |                                   |                 |   |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |  | 22e. ADDRESS  |                                |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| Jeffrey Gaber  |  |                              |  | Mercy Hospital  |                                |   |                                      |   |  |  |  |                                   |                 |   |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |                              |  | 23b. DATE   |                                | 23c. NAME OF CEMETERY OR CREMATORY  |                                      |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |                                   |                 |   |  |                     |  |
| Burial   |  |                              |  | 10/10/1980  |                                | Druid Ridge Cemetery  |                                      |   |  | Pikesville Balto Md  |  |                                   |                 |   |  |                     |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  |                              |  |   |                                | 25a. DATE REC'D. BY REGISTRAR   |                                      | 25b. REGISTRAR'S SIGNATURE                                    |  |  |  |                                   |                 |   |  |                     |  |
| Mitchell-Wiedefeld Home 6500 York Rd.  |  |                              |  |   |                                | OCT 14 1980   |                                      | <u>History &amp; County</u>                                   |  |  |  |                                   |                 |   |  |                     |  |

TO THE  
HONORABLE  
MEMBERS OF THE  
HOUSE OF REPRESENTATIVES

AND  
THE SENATE

IN SENATE  
JANUARY 10, 1900

RECEIVED  
JAN 11 1900  
U. S. SENATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 7 0 2 5 8 8 4<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>EDITH PEARL SWEENEY   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Oct. 15, 1980   |  |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 28 10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>FACTORY WORKER  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MD GLASS CO.   |  |
| 13a. STATE<br>MARYLAND   |  |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH BULLEN  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARY MECKS   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>---   |  | 17. INFORMANT ADDRESS<br>LENORA ELLIOTT 3205 LORENA AVE   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Failure</u><br>586- DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Renal Failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <u>Sepsis</u>                |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hour<br>16 days<br>10 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>July 9 1980  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gangrene of Leg  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 5</u> , 19 <u>80</u> , to <u>Oct 15</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Oct 15</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Kuang-Zong Chen  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>Oct 15, 80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KUANG-ZONG CHEN   |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>10/20/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GLEN HAVEN MEM. PK  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GLEN BURNIE A.A. MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME 4107 WILKENS AVE.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>P. J. [Signature]   |  |

1823  
[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MAY" and "JUN" are faintly visible.]

*[Handwritten signature]*

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ROLLING FOR LARVING FOR NITROGEN

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 8 5

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| ALEXANDRA   |  | SWIDERSKI  |  | 10   |  | 23  |  | 80   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                              |  |
| Female  |  | Caucasian  |  | Dec. 29, 1895  |  | 84  |  | YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | MD.  |  |
| Poland  |  | Poland   |  |  |  | Baltimore City  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| Baltimore   |  | 2851 Lake Ave.   |  | Housewife  |  | -   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |
| Maryland  |  | -  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2851 Lake Ave., 21213                        |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                                |  |
| Alexander   |  | Kojro  |  | No   |  | 220-09-0824   |  | Roman Swiderski, Sr., husband, address same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  | DUE TO, OR AS A CONSEQUENCE OF (c)                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 4140  |  | Congestive Heart failure   |  | Arteriosclerotic heart disease   |  |   |  | 3 yrs.                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |   |  | 10 yrs.                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |
| Carcinoma of Lung - of 2 yrs.   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  |   |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  | CITY OR TOWN  |  | COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/17, 1975, to 10/23, 1980, that (I) (we) lost saw the deceased alive on 10/16, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |  |  |
|   |  | Alan B. Cohen  |  |  |  | 10/24/80  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY           |  |
| ALAN B. COHEN, M.D.   |  | Union Memorial Hospital  |  | Burial   |  | 10/27/80  |  | St. Stanislaus Cem.                          |  |
| 23d. LOCATION   |  | 23e. DATE REC'D. BY REGISTRAR  |  | 23f. REGISTRAR'S SIGNATURE   |  | 23g. REGISTRAR'S SIGNATURE  |  |  |  |
| CITY OR TOWN  |  | OCT 24 1980  |  | Baltimore, Md.   |  |   |  |  |  |
| COUNTY STATE  |  |  |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 24b. ADDRESS   |  | 24c. ADDRESS   |  | 24d. ADDRESS  |  |  |  |
| Schimunek Funeral Home, Inc.  |  | 3321 Brehms Lane Balto., Md. 21213   |  |  |  |   |  |  |  |

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TO HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
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(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 3 8 6  
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KATARZYNA SZYMANIK</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCTOBER 18 1980</b>   |   |  | 2b. HOUR<br>M  |  |  |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4 RACE<br><b>WHITE</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 19 1897</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>16 N. CURLEY STREET</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MARYLAND</b>  |  | 13c. COUNTY<br><b>BALTIMORE</b>   |   | 13d. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13e. STREET ADDRESS<br><b>16 N. CURLEY STREET.</b>                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH WIECZOREK</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b> |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215 16 1908</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MRS. DOROTHY ROBERTSON 9905 PEPPER HILL</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Carcinoma of liver</b><br><b>1552</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>None</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>None</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4-5 MOS</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Congestive heart failure</b>  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>None</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/80</b> 19 to <b>10/18/80</b> 19, that (I) (we) lost<br>saw the deceased alive on <b>10/16/80</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>B. YUKA MD</b>  |  |   |   | DEGREE  |  |  |  | 22c. DATE SIGNED<br><b>21 OCT 80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD YUKA, MD</b>   |  |   |   | 22e. ADDRESS<br><b>Church Hospital, Balto, Md 21231</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10 21 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy ROSARY Em. BALTIMORE, MD.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>RAYMOND L. KACZOROWSKI</b>  |  |   |   | ADDRESS<br><b>2525 FLEET ST.</b>  |  | 25a. DATE RECEIVED BY FUNERAL TRANSIT SERVICE<br><b>OCT 21 1980</b>                  |  |  |  |

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THE  
FACULTY  
OF  
THE  
UNIVERSITY  
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ALBANY  
THIS  
10TH  
DAY  
OF  
JANUARY  
1900

ATTEST  
THE  
VICE-CHANCELLOR  
OF  
THE  
UNIVERSITY  
OF  
THE  
STATE  
OF  
NEW  
YORK

IN WITNESS WHEREOF  
I have hereunto set my hand  
and the seal of the University  
of the State of New York  
at the City of Albany  
this 10th day of January  
1900

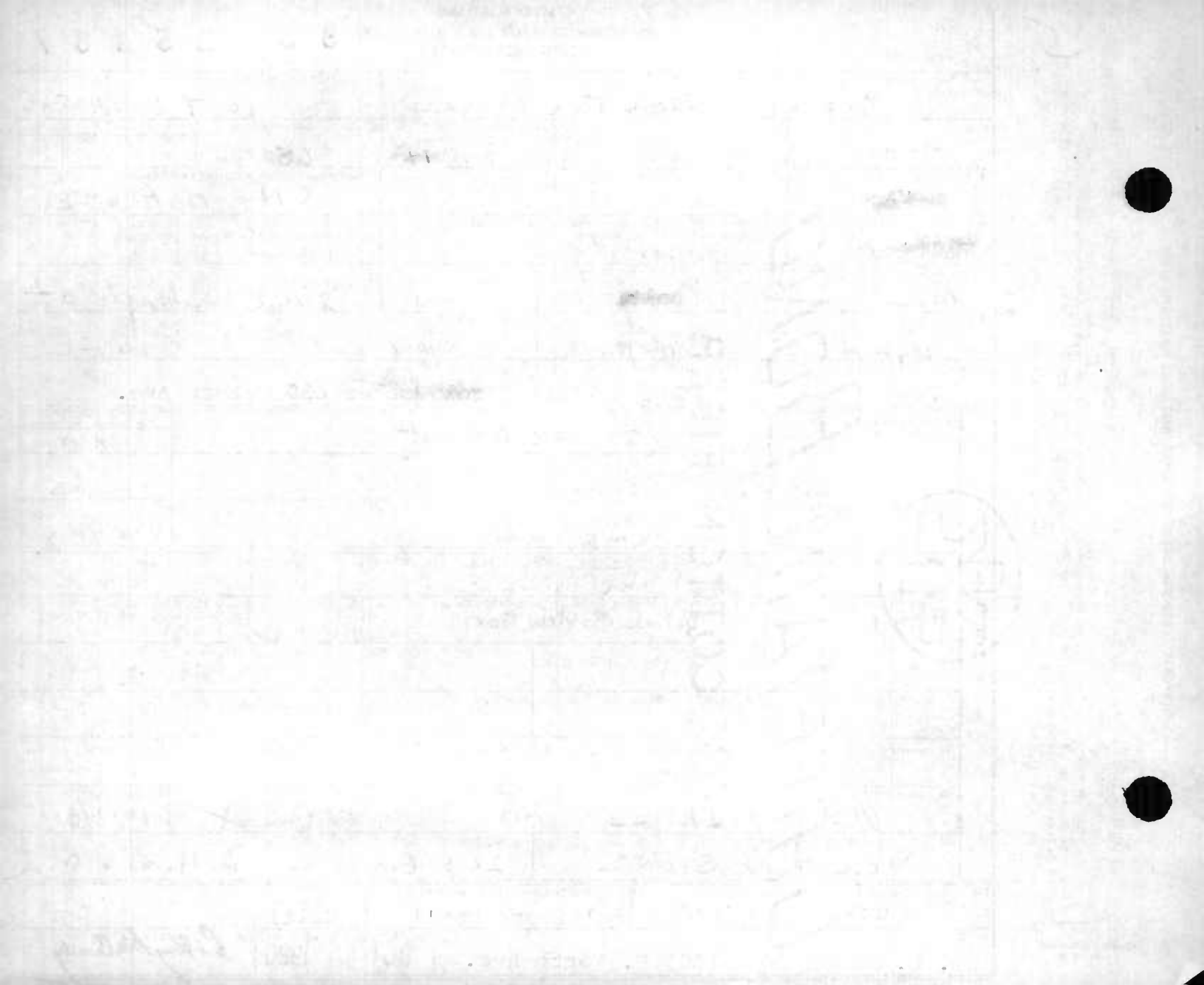
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 0 2 5 8 8 7  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Jerome Ellworth Talbot</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>10 7 80</b>  |  | 2b. HOUR <b>435 A M</b>   |  |  |  |
| 3 SEX <b>male</b>  |  | 4. RACE <b>Negro</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 27 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City, Baltimore MD.</b>                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HOUSE, GIVE STREET ADDRESS)<br><b>University</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2442 Washington St</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HAMMI Talbot</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie P Carter</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218 092015</b>   |  | 17. INFORMANT ADDRESS<br><b>Carol Booker 630 Gutman Ave.</b>                                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>5109 Cardiac Arrest</b><br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Empyema</b>  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min</b><br><b>3 weeks</b><br><b>4 weeks</b>                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)<br><b>Alcoholism</b>  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>9/14/80</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bowel Obstruction</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/12</b> , 19 <b>80</b> , to <b>10/7</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/7</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Nelson N Stone</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>10/7/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Nelson N Stone</b>   |  |  |  | 22e. ADDRESS<br><b>22 S. Greene St Baltimore Md</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>10/13/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat'l</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 8 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Bartholomew</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**RETURN TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_  
DHMH-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |             |   |               |  |  | 8025888  |  |  |  |           |   |            |  |                     |  |
|---|--|--|---|--|-------------|---|---------------|--|--|--|--|--|--|-----------|---|------------|--|---------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  |             |   |               |  |  | REG. NO.   |  |  |  |           |   |            |  |                     |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>JESSE  |  | MIDDLE<br>L |   | LAST<br>TARUN |  | 2a. DATE OF DEATH  |  |  | MONTH<br>10  |  | DAY<br>17 |   | YEAR<br>80 |  | 2b. HOUR<br>8:35 AM |  |
| 3 SEX<br>M  |  |  | 4 RACE<br>W   |  |             | 5. DATE OF BIRTH<br>MONTH<br>8<br>DAY<br>25<br>YEAR<br>11   |               |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.   |  |  | 7. IF UNDER 1 YEAR<br>MONTHS<br>DAYS   |  |           | 8. IF UNDER 7a HRS<br>HOURS<br>MIN.     |            |  |                     |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  | 9b. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |             | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |               |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD  |  |  |  |  |           |   |            |  |                     |  |
| 12. CITY OR TOWN OF DEATH<br>Balto. Md.   |  |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Charles General Ret. Plumber |  |             |   |               |  | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  | 15. KIND OF BUSINESS OR INDUSTRY   |  |           |   |            |  |                     |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>16a. STATE<br>MD   |  |  | 16b. COUNTY<br>Balto.   |  |             | 16c. CITY OR TOWN<br>Balto.   |               |  | 17. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 18. STREET ADDRESS<br>2618 MARYLAND AVE  |  |           |   |            |  |                     |  |
| 19. FATHER'S NAME<br>FIRST<br>HENRY<br>MIDDLE<br>LAST<br>Tarun  |  |  | 20. MOTHER'S MAIDEN NAME<br>FIRST<br>MARIE<br>MIDDLE<br>JUNG<br>LAST  |  |             | 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |               |  | 22. SOCIAL SECURITY NO.<br>215 07 1003   |  |  | 23. INFORMANT<br>Mrs. Katherine Boyle  |  |           | 24. ADDRESS<br>2618 Maryland Ave. 21218 |            |  |                     |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of lung c metastasis<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) COPD<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |             |   |               |  |  | 26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 months |  |  |  |           |   |            |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |  |             |   |               |  |  |  |  |  |  |           |   |            |  |                     |  |
| 27a. DATE OF OPERATION  |  |  | 27b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |             |   |               |  | 28a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |  | 28b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |           |   |            |  |                     |  |
| 29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 29b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |             | 29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |               |  |  |  |  |  |  |           |   |            |  |                     |  |
| 30a. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 30b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |             | 30c. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |               |  |  |  |  |  |  |           |   |            |  |                     |  |
| 31. I certify that (I) (this hospital) attended the deceased from 10/5 19 80 to 10/17 19 80, that (I) (we) last saw the deceased alive on 10/17 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |             |   |               |  |  |  |  |  |  |           |   |            |  |                     |  |
| 32a. SIGNATURE<br>A.C. Chouvalit  |  |  |   |  |             | 32b. DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |               |  | 32c. DATE SIGNED<br>10/17/80   |  |  |  |  |           |   |            |  |                     |  |
| 33a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.C. CHOUVALIT, M.D.   |  |  |   |  |             | 33b. ADDRESS<br>North Charles General Hosp.   |               |  |  |  |  |  |  |           |   |            |  |                     |  |
| 34a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 34b. DATE<br>Oct. 20 1980   |  |             | 34c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.  |               |  | 34d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Balto. Md.                                 |  |  |  |  |           |   |            |  |                     |  |
| 35. FUNERAL DIRECTOR<br>NAME<br>G. Truman Schwab 3512 Frederick Ave. 21229  |  |  |   |  |             | 36. DATE REC'D. BY REGISTRAR<br>OCT 23 1980   |               |  | 37. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |  |           |   |            |  |                     |  |

7710 . O + 135

Not a member

of [redacted]

[illegible]

0821 2 5 TCD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  | REG. NO. 50 25889  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MON / DAY / YEAR                                  |  |
| ERNEST H. TAWNEY   |  |  |  |   |  |   |  | 10 / 15 / 80  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | 7b. HOUR  |  |
| Male   |  | White  |  | Oct. 31, 1909   |  | 70  |  | 8:45 P.M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |   |  |
| Virginia   |  | USA  |  |   |  | Baltimore City  |  | MD.   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |
| Baltimore  |  | Bon Secours Hospital   |  | None  |  | None  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |  |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS   |  |   |  |   |  |
| Phillip  |  | Louise   |  | 1602 Park Avenue  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |  | ADDRESS   |  |   |  |
| No   |  | 234 03 6862  |  | Leavitt Funeral Home, W. Virginia   |  | 403 W. 7th St.,   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Sepsicemia</u>  |  |  |  |   |  |   |  |   |  |
| 7070 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple Decubitus ulcers</u>   |  |  |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
|  |  | P.M. 19  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET  |  | CITY OR TOWN  |  | COUNTY STATE  |  |
|  |  |  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/15/80</u> 19 <u>80</u> , to <u>10/15/80</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/15/80</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>              |  | 22c. DATE SIGNED  |  |   |  |
| <u>T. Lin,</u>   |  | MD   |  |   |  | 10/15/80  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |   |  |
| T LIN, MD  |  | Bon Secours Hospital   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY STATE  |  |
| Removal-Burial   |  | 10/19/80   |  | Mt. Zion Cemetery   |  | Belleville,   |  | W. Va.  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  |  | 24b. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Henry W. Jenkins & Sons Co.  |  |  |  | 4905 York Road Balto., Md. 21212  |  | OCT 17 1980   |  | <u>Robert M. Brady</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M  
(VRA 15.4) 1/79

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25890  
REG. NO.

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Benjamin Arthur Taylor   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct 4 1980                                    |   |   | 2b. HOUR<br>M  |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-24-1913  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Agnes Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Machine Operator   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Concrete Co.  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Howard  |   | 13c. CITY OR TOWN<br>Elkridge   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Taylor  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hona Newton                         |   |   | 13e. STREET ADDRESS<br>5806 Race Road 21207  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>World War II 1213-01-2021 |   |   | 17. INFORMANT<br>ADDRESS<br>Hilda Taylor 5806 Race Road  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION SINOBRONCHIAL<br>2500<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) HYPERTENSION<br>(c) DIABETES |  |   |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-4-80 to 10-4-80, that (I) (we) saw the deceased alive on 10-4-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                        |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>George E. Groblewski  |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>10-5-80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GEORGE E GROBLEWSKI  |  |   | 22e. ADDRESS<br>5849 WASHINGTON BLVD<br>BALTIMORE MD                                 |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Oct 9 1980  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Nat. Cem. Baltimore City Maryland |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Herbert E. Nutter   |  |   | ADDRESS<br>3035 W. North Ave   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>H. E. Nutter   |  |

BP.

M

Received of Mr. J. H. Taylor

the sum of £100

for the purchase of

the property of

the late Mr. J. H. Taylor

of the County of

Gloucestershire

the sum of £100

being the purchase price

of the property of

the late Mr. J. H. Taylor

of the County of

Gloucestershire

the sum of £100

being the purchase price

of the property of

the late Mr. J. H. Taylor

of the County of

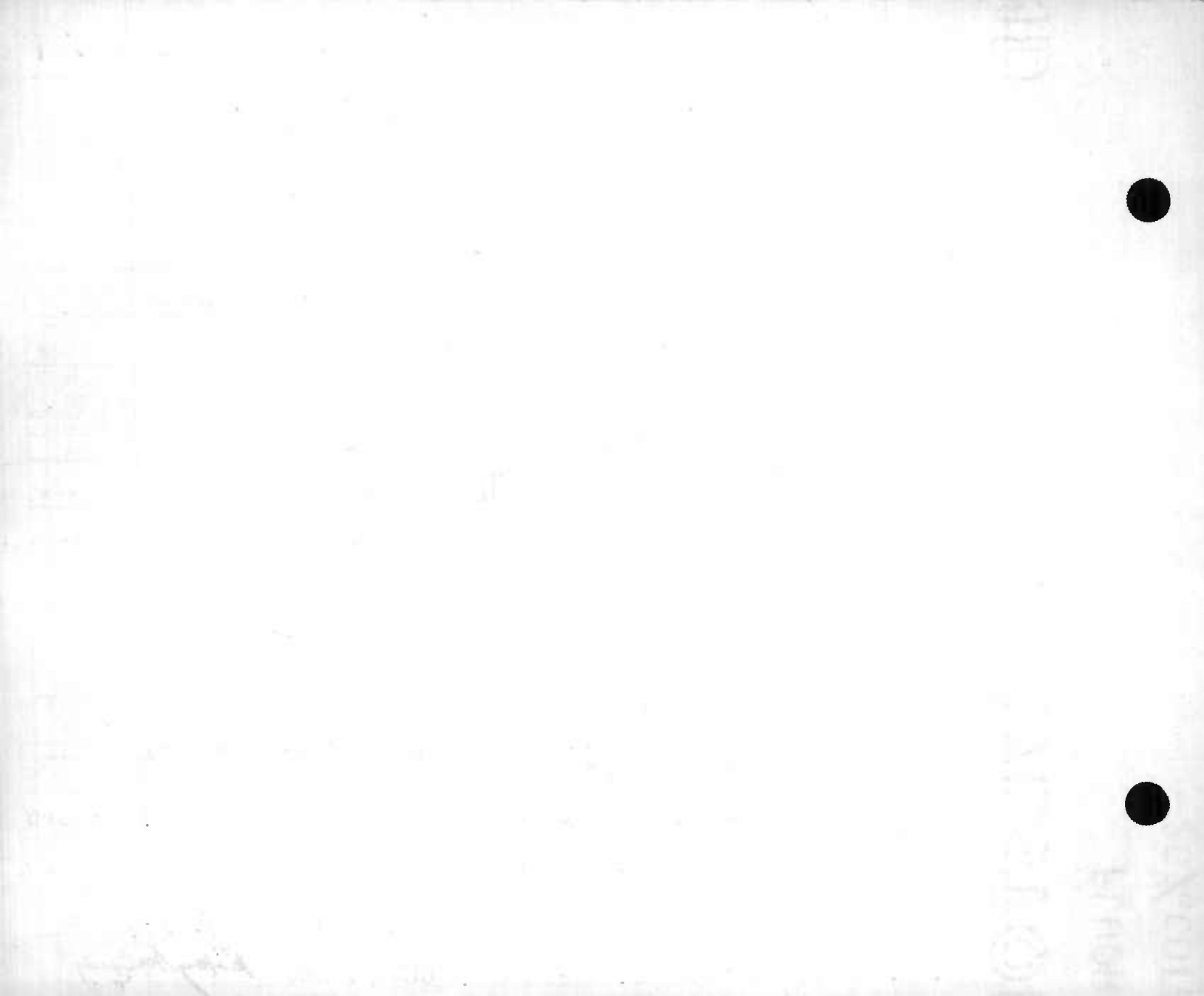
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 80  |  | 25891  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CATHERINE E. TAYLOR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 9, 1980  |  | 2b. HOUR<br>M  |  |  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Negro   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>4 <sup>th</sup> 25 22  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>58   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN HOSPITAL, GIVE STREET ADDRESS)<br>1129 Poplar Grove St. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>1129 Poplar Grove St.   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Charles POLLARD   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lillie  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-12-6559  |  | 17. INFORMANT ADDRESS<br>Thomas Taylor 1129 Poplar Grove St.   |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>1830<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intractable Pleural effusion</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic Ovarian Carcinoma</u> |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>4 weeks</u><br><u>6 years</u>                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 3</u> 19 <u>80</u> to <u>October 9</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>October 3</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><u>Olusegun O. Lawoyin</u>  |  |   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>Oct 13, 1980   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OLUSEGUN O. LAWOTIN  |  |   |  | 22d. ADDRESS<br>5101 LANIER Ave, Baltimore, MD 21215   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10/14/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD   |  | 23e. DATE REC'D. BY REGISTRAR<br>OCT 14 1980   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |   |  | ADDRESS<br>1101 E. North Ave.  |  | 23f. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |



See item 18-22 Film G 55124191  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

2 5 8 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
 DonNA LYNN Taylor

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR  
 10 18 80

2b. HOUR  
 4:59 a.m.

3. SEX F 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR 12-12-1963 16 YRS. 6. AGE (IN YEARS LAST BIRTHDAY) 16 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 18 80

7d. HOUR a.m.

7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD 7f. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1135 E. Balto. St., 2nd floor 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD 13c. CITY OR TOWN HARFORD 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 1002 WARWICK DR. APT # 1A

14. FATHER'S NAME FIRST MIDDLE LAST CHARLES EIMER TAYLOR 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLADYS VIRGINIA DEANER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 214-92-1076 17. INFORMANT ADDRESS JAMES MARSHBURN ABERDEEN MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotism 3049  
 DUE TO, OR AS A CONSEQUENCE OF  
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
 (b)  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Margaret Brecknell M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-18-80

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL 23b. DATE 10-23-1980 23c. NAME OF CEMETERY OR CREMATORY HARFORD mem. GARDEN ALDING 23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD MD

24. FUNERAL DIRECTOR NAME Pennington & Son ADDRESS Grace de Grace, Md. 25a. DATE RECEIVED BY REGISTRAR OCT 22 1980 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15.4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |   | 8025893 |  |
|--|--|--|--|---|--|---|--|---|---|---------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |  |   |   |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy ELIZABETH Taylor  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 7 80  |  | 2b. HOUR<br>8 <sup>30</sup> AM  |   |         |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 15 1927  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.  |  |   |   |         |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |         |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>506 Makee St.  |   |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George (Wm) Byrd   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susie Fortune  |  |   |  |   |   |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-05-7754   |  | 17. INFORMANT<br>ADDRESS<br>ELAINE ROBINSON 1518 RETREAT ST.  |  |   |  |   |   |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIO PULMONARY Failure<br>1459<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Metastatic Squamous Cell Carcinoma of Mouth<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                    |  |  |  |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |   |         |  |
| 19a. DATE OF OPERATION<br>8/21/80  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Squamous Cell Carcinoma  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |   |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |   |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/31, 19 80, to 10/7, 19 80, that (I) (we) lost saw the deceased alive on 10/7, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. |  |  |  |   |  |   |  |   |   |         |  |
| 22b. SIGNATURE<br>William Polito MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>10/7/80   |   |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Polito  |  |  |  | 22e. ADDRESS<br>UNIVERSITY OF MARYLAND Hospo.   |  |   |  |   |   |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/11/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md.                                       |  |   |   |         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Vernon R. Bailey 1348 Calhoun St.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 10 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Ricky McHenry   |  |   |   |         |  |

MEDICAL CERTIFICATION

Business Paper

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers and place them in the envelope provided. Page 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 5 8 9 4   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GLADYS HARCUM TAYLOR</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 31 80</b>  |  | 2b. HOUR<br><b>2:50 P.M.</b>   |   |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>B</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 -19-1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Johns Hopkins Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Teacher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Public School</b>  |   |
| 13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William C. HARCUM</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Bowler</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-12-5780</b>  |  | 17. INFORMANT ADDRESS<br><b>George L. Taylor-2525 Madison Ave.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br><b>436°</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>atherosclerotic disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mos.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>10/31</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10/31</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Mary Hotchkiss</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10/31/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARY HOTCHKISS</b>   |  |  |  | 22e. ADDRESS<br><b>601 N. BROADWAY JOHNS HOPKINS</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/4/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Murkirk, Maryland</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Herbert E. Nutter-3035 W. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>  |  |  |   |

0 04P ed 22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 8 9 5

REG. NO.

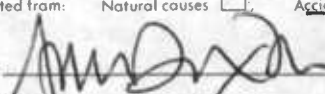

|  |  |   |   |  |  |  |   |  |   |  |
|--|--|---|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Grace Elizabeth Taylor  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 29, 1980                 |  |  | 2b. HOUR<br>P M<br>3:00 P M  |   |  |   |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 16, 1904   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>305 Wyman Park Drive |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dental  |   |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>---  |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>305 Wyman Park Dr. 21211 |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence J. Taylor  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lottie P. Glanville    |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215.18.5011A |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Mabel A. Kirby---Same as 13e                  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cx of Lung</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Generalized Paraneoplastic</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs</u> |  |   |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 10-27-80</u> to <u>Jan 10</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Jan 10</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did/did not) view the body after death.   |  |   |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Lawrence J. Shumanek M.D.</u>   |  |   |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>10-29-80</u>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Lawrence J. Shumanek</u>   |  |   |   |  |  | 22e. ADDRESS<br><u>3711 Falls Rd</u>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |   | 23b. DATE<br>10/30/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Walter Brooks Bradley Inc., Balto Md 21222   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1980   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Robert Ball...</u>  |   |  |

$\alpha$   $\beta$   $\gamma$   $\delta$   $\epsilon$   $\zeta$   $\eta$   $\theta$   $\iota$   $\kappa$   $\lambda$   $\mu$   $\nu$   $\xi$   $\omicron$   $\pi$   $\rho$   $\sigma$   $\tau$   $\upsilon$   $\phi$   $\chi$   $\psi$   $\omega$

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/76

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |   |  |  |   |  | REG. NO. 25896                               |  |
|--|-------------------------|--|---|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |                         |  |   |   |   |  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RONALD LEE TAYLOR, Jr.</b>  |                         |  |   |   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>10</b> DAY <b>8</b> YEAR <b>1980</b>           |  | 2b. HOUR <b>6:05</b> AM   |  |  |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>27</b> YEAR <b>64</b>  | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>16</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>10</b> DAY <b>8</b> YEAR <b>1980</b>  |  | 2d. HOUR <b>6:05</b> PM   |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b> MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>High School</b>   |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |                         |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  |  |  |
| 13e. STREET ADDRESS<br><b>5 Payson Avenue</b>  |                         |  |   |   |   |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Ronald</b> MIDDLE <b>Lee</b> LAST <b>Taylor</b> SR <b>Sr</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Nancy</b> MIDDLE <b>Donavin</b> LAST <b>Donavin</b>  |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |                         |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Ronald Lee Taylor, Sr. Same as #13</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>8151. IMMEDIATE CAUSE (a) Cranio-cerebral &amp; neck trauma</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                         |  |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6:32 PM 10-5-1980</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Passenger in auto/fixed object impact.</b>   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>  |   | 21f. LOCATION<br>STREET <b>Rt. 50 near Naylor Mill Rd.</b> CITY OR TOWN <b>Salisbury</b> COUNTY <b>Wicomico</b> STATE <b>Md.</b> |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                         |  |   |   |   |  |  |   |  |  |  |
| ACTUAL SIGNATURE    |                         |  |   | TITLE (SPECIFY)<br><b>Assistant</b>   |   |  |  | DATE SIGNED <b>10-9-80</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |                         |  |   | ADDRESS<br><b>111 Penn St.</b>  |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |  |   | 23b. DATE<br><b>10/11/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Woodlawn</b> COUNTY <b>Balto</b> STATE <b>Md.</b>                                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Witzke Funeral Home of Catonsville</b> ADDRESS <b>1630 Edmondson Avenue Catonsville, Maryland</b>  |                         |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |

THE UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
WASHINGTON, D. C. 20315

TO: THE SECRETARY OF THE ARMY  
FROM: THE CHIEF OF STAFF  
SUBJECT: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]

6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]

11. [Illegible]  
12. [Illegible]  
13. [Illegible]  
14. [Illegible]  
15. [Illegible]

16. [Illegible]  
17. [Illegible]  
18. [Illegible]  
19. [Illegible]  
20. [Illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 8 9 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |                                   |
|--|---|---|--|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Willie Marie Taylor</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 26 80</b>             |  | 2b. HOUR<br><b>2:45 AM</b>        |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YR.<br><b>11 17 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                            |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>T. L. Deaton Medical Ctr.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>                              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |                                   |
| 14. FATHER'S NAME<br>MIDDLE LAST<br><b>Thomas Hicks</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br><b>Elizabeth Porter</b> |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>220-20-8723A</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>John Taylor 2026 Braddish Avenue</b>                          |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest &amp; Cardiac Arrest</b><br><b>4360</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebral Vascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>High Blood Pressure, 2nd Stage</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1979</b> |   |   |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |  |                                   |
| 19a. DATE OF OPERATION<br><b>(1)</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>(1)</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>(1)</b> |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>0/12/80</b> , 19 <b>80</b> , to <b>10/26/80</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/26/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |                                   |
| 22b. SIGNATURE<br><b>James A. F. Ch. 10</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>10/26/80</b>  |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMUEL A. DOUGLAS MD</b>   |   | 22e. ADDRESS<br><b>225 Green St. City of Md. Hgts.</b>  |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>10/31/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>                               |                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1980</b>   |  |  |                                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1980</b>  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 8 9 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>VINCENT</b> <b>TENACE</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 18 80</b>   |  | 2b. HOUR<br><b>7:15 PM</b>                        |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 29 88</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>92</b> YRS.                                      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ITALY</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John Deaton Medical Center</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>self employed</b> |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>-</b> 13c. CITY OR TOWN <b>Balto.</b> |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5602 Narcissus Ave.</b> |
| 14. FATHER'S NAME<br>FIRST <b>Nickolas</b> MIDDLE <b>Tenace</b> LAST <b>Tenace</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Celsomina</b> MIDDLE <b>Moliverlo</b> LAST <b>Moliverlo</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>213-26-4236</b>  |   | 17. INFORMANT ADDRESS<br><b>ALMA Hurley - same - 21215</b>                               |   |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |  |  |
| (b) <b>DYSPHAGIA WITH RECURRENT ASPIRATION</b>   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC BRAIN SYNDROME</b>  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SUBDURAL HEMATOMA - ADVANCED DECUBITUS ULCERS</b>  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 19 71</b> to <b>OCT-18 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/17 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Joseph D. Notarangelo</b>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>10/18/1980</b>  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOSEPH D. NOTARANGELO</b>  |  | 22c. ADDRESS<br><b>M.D., 301 ST. PAUL PLACE BALTO 21202</b>            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/20/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1980</b>                    |  | 23f. REGISTRAR'S SIGNATURE<br><b>Barry K. Brady</b>                                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.N. ZANNINO</b>  |  | 24b. ADDRESS<br><b>263 S. CONKLING ST. BALTO.</b>                      |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 5 8 9 9

|  |  |  |   |   |   |  |   |  |  |  |
|--|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HELEN ADELE THAW</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 20 80</b>                    |   |   | 2b. HOUR<br><b>10 45</b> AM  |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 05 93</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3327 WINTERBOURNE ROAD</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>COMMERCIAL ARTIST</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. STORE</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>--</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3327 WINTERBOURNE ROAD</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GRAYSON W. SHARRETT</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAUDE A. SHARRETT</b> |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-2372</b>                            |   | 17. INFORMANT<br>ADDRESS<br><b>WILLIAM C. THAW 3327 WINTERBOURNE ROAD</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cancer</i><br><b>1889</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cancer of Urinary Bladder</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <i>With Metastases</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Arteriosclerosis and Cerebrovascular arterio Sclerotic disease</i> |  |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| 19a. DATE OF OPERATION<br><b>--</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>--</b>             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>         |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 7th</i> 19 <i>80</i> , to <i>Oct 20</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>Oct 20</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Dr. Paul Byerly</i> DEGREE <i>M.D.</i>  |  |  |   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>Oct 21 1980</i>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL BYERLY, M.D.</b>  |  |  |   |   |   | 22e. ADDRESS<br><b>6415 MURRAY HILL ROAD</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  |  | 23b. DATE<br><b>10-22-80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>                    |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |  | ADDRESS<br><b>4107 WILKENS AVE.</b>                                       |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1980</b>  |   | 25b. SIGNATURE<br><i>Ray H. H. H.</i>  |  |  |

STATE OF NEW YORK  
IN SENATE  
JANUARY 11, 1900  
REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899

ALBANY: J. B. LEECH, STATE PRINTER.  
1900.

1899 63 700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 0 2 5 9 0 0  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1 - STATE REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH  |  |   |  |
| GEORGE FREDERICK THEROUX   |  |   |  | October 17, 1980   |  |   |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | 2b. HOUR  |  |
| Male   |  | White   |  | Aug. 6, 1913   |  | 5:50a M   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 8. IF UNDER 1 YEAR  |  |
| New York   |  | USA   |  | 67 YRS.  |  | MONTHS DAYS HOURS MIN.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  |
| Baltimore  |  | Maryland General Hospital   |  | Baltimore City MD.   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS  |  |   |  |
| George   |  | Bessie  |  | 3501 St. Paul Street #837  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |
| Yes  |  | U.S.A. 528 18 3039  |  | Mrs. Edith H. Theroux  |  | Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (a) Multiple ischemic areas of small Bowel with Peritonitis  |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |   |  |
| (b) Arteriosclerotic cardiovascular disease with   |  |   |  |  |  |   |  |
| Thrombus in distal aorta   |  |   |  |  |  |   |  |
| (c)  |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
| 10/14/80   |  | Multiple small bowel perforations   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  | P.M. 19   |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |
| WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from October 7, 1980, to October 17, 1980, that (we) lost saw the deceased alive on October 17, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did (not) view the body after death.) |  |   |  |  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| Anthony Tan  |  | M.D.  |  |  |  | 10/17/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |   |  |
| Anthony Tan, M.D.  |  | c/o Maryland General Hospital   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Cremation  |  | 10/18/80  |  | Security Process   |  | Baltimore, Md.  |  |
| 24. FUNERAL DIRECTOR   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., Md. 21212  |  |   |  | OCT 20 1980  |  | Anthony Tan   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |   |  |   | 8 0 2 5 9 0 1<br>REG. NO.  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|---|--|---|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |   |   |  |   | 2a. DATE OF DEATH  |  |  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>DOROTHY L. THOMAS   |  |  |  |  |  |   |   |  |   | Oct 29 1980  |  |  |  | 4:55 AM   |  |   |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 18 1892   |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS                                   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                  |  |  |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |  |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Schoolteacher |  |   |  |   |  |
| 13a. STATE<br>Maryland  |  |  |  |  |  |   |   |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3838 Roland Ave. Apt. 1009 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William L. Thomas   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Ehrhart |   |   |  |   |  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--  |  |  | 17. INFORMANT ADDRESS<br>Miss Elizabeth Deussen 501 Castle Dr.  |   |  |   |  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>3940 DUE TO, OR AS A CONSEQUENCE OF<br>(b) Mitral stenosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) Atherosclerotic Cardiovascular disease<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2-3 weeks<br>years |  |  |  |  |  |   |   |  |   |  |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):<br>none  |  |  |  |  |  |   |   |  |   |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>none  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)   |   |  |   |  |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |  |  |   |  |   |  |
| 22a. I certify that this hospital attended the deceased from Oct 16, 1980, to Oct 29, 1980, that (we) last saw the deceased alive on Oct 29, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)  |  |  |  |  |  |   |   |  |   |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Rhoads Stevens MD   |  |  |  |  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |   |  |   | 22c. DATE SIGNED<br>10/29/80   |  |  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rhoads Stevens MD  |  |  |  |  |  | 22e. ADDRESS<br>201 E. Univ. Pkwy Balto 21218   |   |  |   |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>Burial  |  |  | 23b. DATE<br>11/1/80   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cem.  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.                 |  |  |  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitz   |  |  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 5 1980  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]                                   |  |  |  |  |   |  |   |  |
| ADDRESS<br>Funeral Home 3818 Roland Ave.  |  |  |  |  |  |   |   |  |   |  |  |  |  |   |  |   |  |



| NAME      | AGE | SEX    | RACE  | DATE OF BIRTH | DATE OF DEATH | PLACE OF BIRTH | PLACE OF DEATH | CAUSE OF DEATH | DATE OF BURIAL | PLACE OF BURIAL |
|-----------|-----|--------|-------|---------------|---------------|----------------|----------------|----------------|----------------|-----------------|
| William   | 21  | Male   | White | 1892          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |
| Alice     | 18  | Female | White | 1894          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |
| Thomas    | 15  | Male   | White | 1897          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |
| John      | 12  | Male   | White | 1900          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |
| Mary      | 10  | Female | White | 1902          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |
| Robert    | 8   | Male   | White | 1904          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |
| Elizabeth | 6   | Female | White | 1906          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |
| Charles   | 4   | Male   | White | 1908          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |
| William   | 2   | Male   | White | 1910          | 1913          | St. Louis, Mo. | St. Louis, Mo. | Heart Disease  | Jan. 1, 1913   | St. Louis, Mo.  |

St. Louis, Mo. 1913

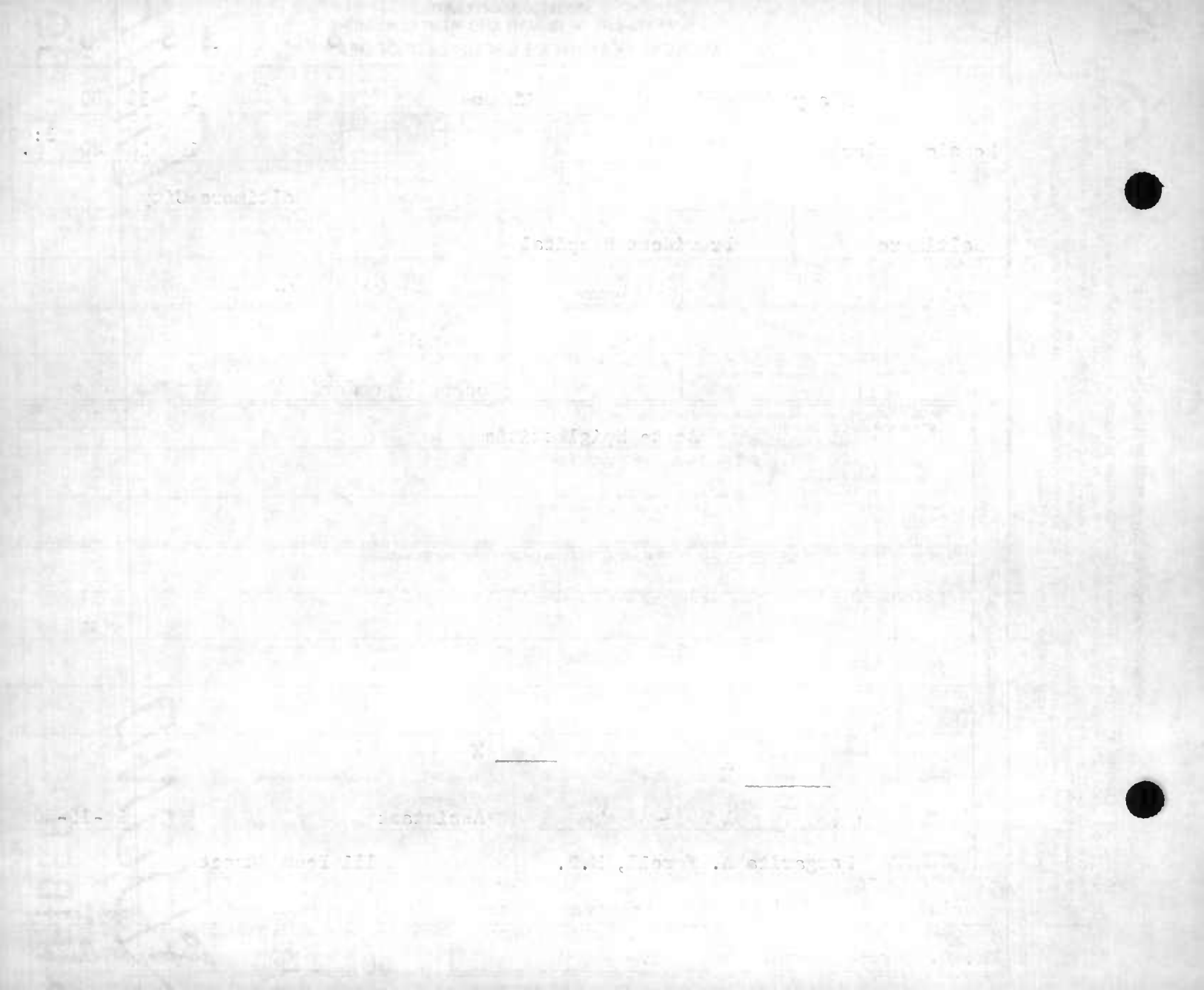
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
1VR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                         |   |  |   |   |   |   |  |
|---|-------------------------|---|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ebany (Ebony) O. Thomas</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br><b>10 18 1980</b> |   |   | 2b. HOUR<br>M<br><b>3:00 p.m.</b>   |   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 11 74</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>6 YRS.</b>  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>10 18 1980</b>                                 |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 13e. STREET ADDRESS<br><b>4208 Fair Fax Road</b>  |                         |   |  |   |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Thomas</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rosenell Munford</b>   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |   | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT ADDRESS<br><b>Rosenell Munford 4208 Fair Fax Road</b>                             |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Epiglottitis</b><br>4643<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |                         |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>  |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>  |   |   | DATE SIGNED<br><b>10-19-80</b>  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         |   | ADDRESS<br><b>111 Penn Street</b>  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         |   | 23b. DATE<br><b>10/23/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Cemetery</b>                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>             |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March Funeral Home Inc.</b>   |                         |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1980</b>                           |   | 25b. REGISTRAR'S SIGNATURE<br><i>Barney A. Brady</i>                                |  |

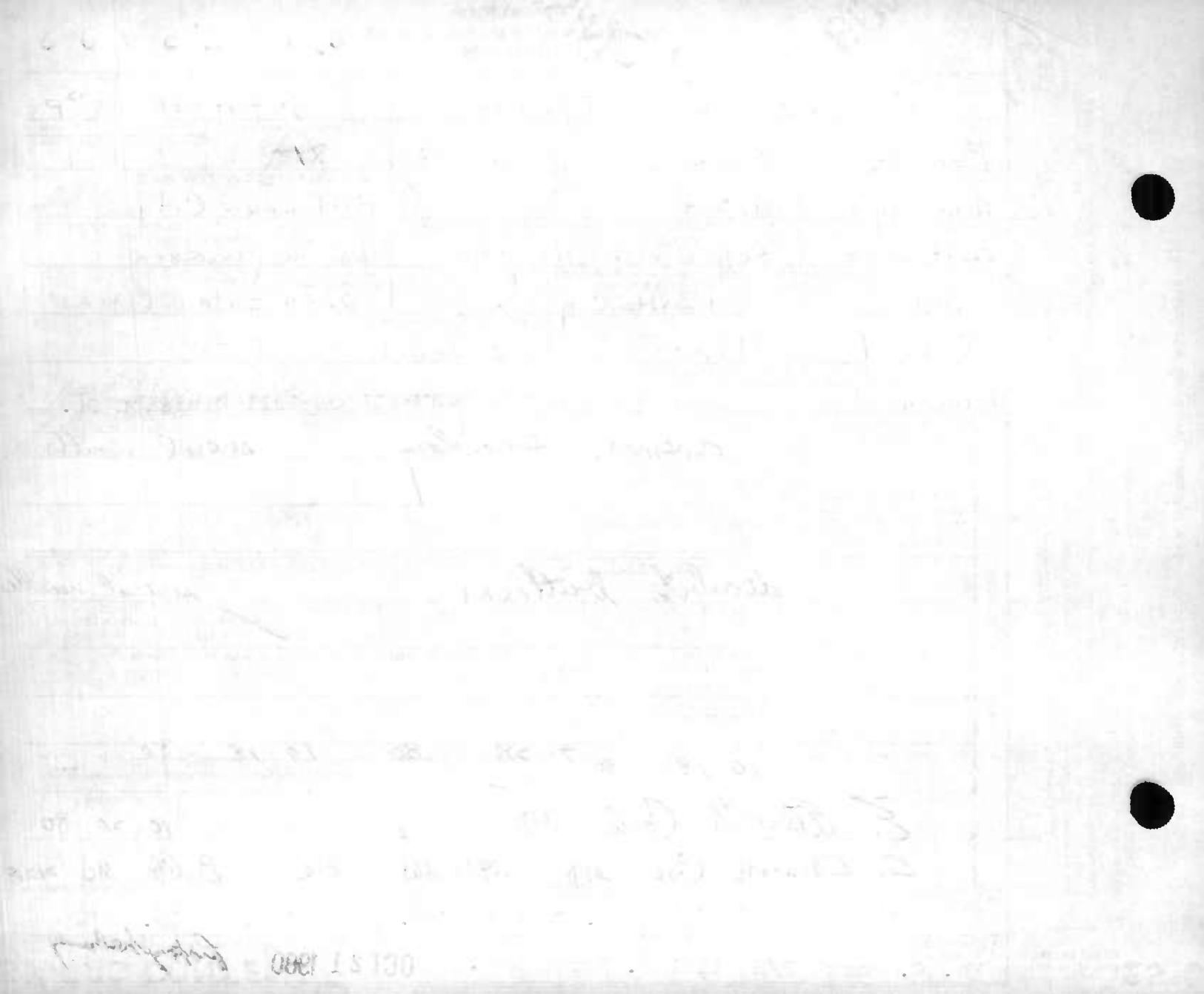


TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

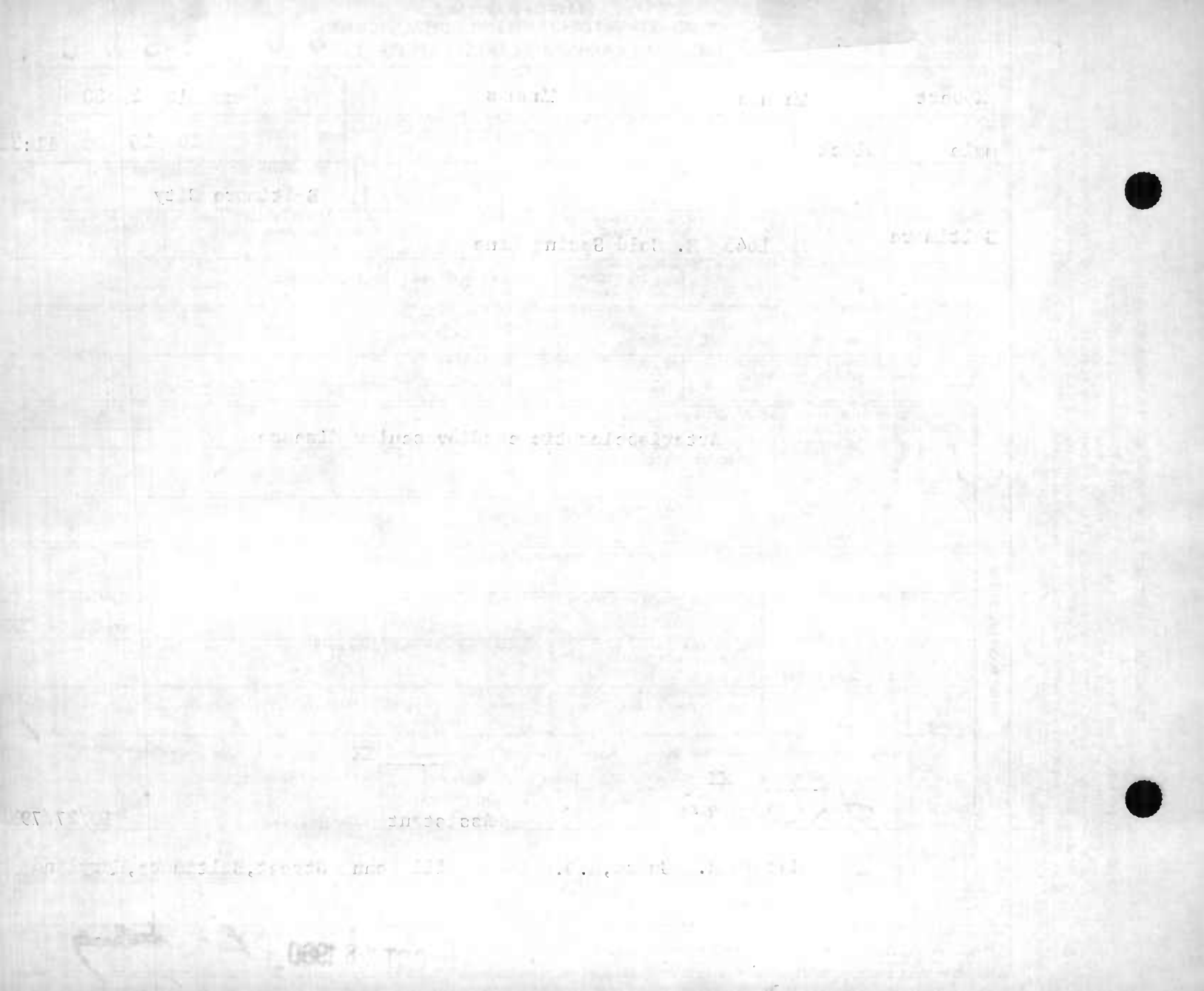
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                     |  | 8025903         |     |           |          |
|--|--|--|--|--|--|---|--|---------------------|--|-----------------|-----|-----------|----------|
| FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |                     |  |                 |     |           |          |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH           | DAY | YEAR      | 2b. HOUR |
| Eleanor A. Thomas  |  |  |  |  |  |   |  | 10-18-80            |  |                 |     |           | 945 P M  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS |     |           |          |
| Female   |  | Black  |  | 11-16-03   |  | 71 YRS  |  | MONTHS              |  | DAYS            |     | HOURS MIN |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |                 |     |           |          |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore City MD.  |  |                     |  |                 |     |           |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                 |     |           |          |
| Baltimore  |  | Key Circle Hospice   |  | Laundry Worker   |  |   |  |                     |  |                 |     |           |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                 |     |           |          |
| md.  |  |  |  | Baltimore City   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 2234 Eutaw Place    |  |                 |     |           |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                     |  |                 |     |           |          |
| Richard Thomas   |  | Sedonia Pitts  |  |  |  |   |  |                     |  |                 |     |           |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |                     |  |                 |     |           |          |
| Unknown  |  | 218-18-1555  |  | THEODORE WILSON 1911 Division St.  |  |   |  |                     |  |                 |     |           |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anemia, secondary several months.  |  |  |  |  |  |   |  |                     |  |                 |     |           |          |
| 2859   |  |  |  |  |  |   |  |                     |  |                 |     |           |          |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |  |   |  |                     |  |                 |     |           |          |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |                     |  |                 |     |           |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) death butlocks several months.   |  |  |  |  |  |   |  |                     |  |                 |     |           |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                 |     |           |          |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                 |     |           |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | 21d. PLACE OF INJURY  |  |                     |  |                 |     |           |          |
|  |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | CITY OR TOWN COUNTY STATE   |  |                     |  |                 |     |           |          |
| 21e. INJURY OCCURRED   |  | 21f. LOCATION  |  |  |  |   |  |                     |  |                 |     |           |          |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | STREET   |  |  |  |   |  |                     |  |                 |     |           |          |
| 22. I certify that (I) (this hospital) attended the deceased from 7-28-80 to 10-18-80, that (I) (we) lost saw the deceased alive on 10-18-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                     |  |                 |     |           |          |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |                     |  |                 |     |           |          |
| E. Ellsworth Cook  |  | MD   |  | 10-20-80   |  |   |  |                     |  |                 |     |           |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |                     |  |                 |     |           |          |
| E. Ellsworth Cook MD   |  | 2431 MD. Ave. Balt. Md. 21218  |  |  |  |   |  |                     |  |                 |     |           |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |                     |  |                 |     |           |          |
| Burial   |  | 10/22/80   |  | Mt. Calvary Cem.   |  | Baltimore Co. MD  |  |                     |  |                 |     |           |          |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                     |  |                 |     |           |          |
| NAME ADDRESS   |  | OCT 21 1980  |  | [Signature]  |  |   |  |                     |  |                 |     |           |          |
| Wm. C. March F/H   |  | 1101 E. North Ave.   |  |  |  |   |  |                     |  |                 |     |           |          |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |  |  |   |  | REG. NO. 2 0 2 5 9 0 4   |                                   |  |
|--|--|----------------------|--|---|--|--|--|---|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Robert C. Thomas</b>  |  |                      |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH <b>10</b> DAY <b>25</b> YEAR <b>80</b>                                    |  |   | 2b. HOUR <b>M</b>  |  |                                   |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>black</b> |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>21</b> YEAR <b>15</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.         |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>10</b> DAY <b>26</b> YEAR <b>80</b>                     |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.       |  |                                   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1645 E. Cold Spring Lane</b> |   |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. STATE <b>Md.</b>  |  |                      |  |   |  | 13b. COUNTY <b>Balto.</b>  |  | 13c. CITY OR TOWN <b>Balto.</b>               |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>Clavon</b> MIDDLE LAST <b>Thomas</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Unkn</b> MIDDLE LAST  |  |   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>218-07-8833</b>                       |  | 17. INFORMANT ADDRESS<br><b>Walter E. Thomas 4310 Maine Ave.</b>   |  |   |  |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                      |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |   |  |  |  |   |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |                                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |   |  |  |                                   |  |
| ACTUAL SIGNATURE <b>H.R. Guard</b>   |  |                      |  | TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER            |  |  |  | DATE SIGNED <b>10/27/1980</b>                 |  |  |                                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn Street, Baltimore, Maryland</b>               |  |  |  |   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>11/1/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King Mem. Park</b>   |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore Co., Md.</b> COUNTY STATE |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |  |                      |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 28 1980</b>                  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b> |  |  |                                   |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

284/BP

DHMH - 17  
IVR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                         |   |  |   |  |   |   |  |   |  |                               |
|---|-------------------------|---|--|---|--|---|---|--|---|--|-------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Samathis Thomas<br/>Samanthia</b>   |                         | FIRST<br><b>Thomas</b>  |  | MIDDLE<br><b>Thomas</b>   |  | LAST<br><b>Thomas</b>   |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> 10 5 19 80 |   | 2b. HOUR<br>M                                |                               |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MO. DAY YEAR<br><b>Dec. 5, 1965</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>YEARS<br><b>14</b>  | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>14</b> |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>14</b> |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>10 5 19 80</b> |  | 2d. HOUR<br>M<br><b>11:30</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |  |   |  |                               |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>0</b>  |   |  |                               |
| 13a. STATE<br><b>Md.</b>  |                         | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>3710 Milford Ave.</b>  |   |  |                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Mahlon Thomas</b>  |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Joyce Timmons</b>   |  |   |   |  |   |  |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>0</b>   |                         |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>0</b>  |  | 17. INFORMANT ADDRESS<br><b>Joyce Thomas, 3710 Milford Ave.</b>                                 |   |  |   |  |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>Osteo-sarcoma, femur</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |  |   |  |   |   |  |   |  |                               |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |   |  |                               |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |  |   |  |                               |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |   |  |                               |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |   |   |  |   |  |                               |
| ACTUAL SIGNATURE<br><b>[Signature]</b>  |                         | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  |   |   | DATE SIGNED<br><b>10/6/80</b>  |   |  |                               |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Hormez R. Guard, MD</b>   |                         | ADDRESS<br><b>111 Penn Street, Baltimore, MD</b>  |  |   |  |   |   |  |   |  |                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>Burial</b>   |                         | 23b. DATE<br><b>10/10/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>West View Mem. Pk.</b>   |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>               |   |  |                               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Law Funeral Home 4611 Park Heights Ave.</b>  |                         |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1980</b><br><b>[Signature]</b>                       |   |  |   |  |                               |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 0 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
|---|--|--|-------------------|---|----|---|----|---|----|---|------|---|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 20. DATE OF DEATH |   |    | MONTH   |    | DAY   |    | YEAR  |      | 2b. HOUR  |  |                              |  |
| Catherine L. Thompson   |  |  | 10-11-80          |   | 10 |   | 11 |   | 80 |   | 1013 |   |  |                              |  |
| 3. SEX  |  | 4. RACE  |                   | 5. DATE OF BIRTH  |    | 6. AGE (IN YEARS LAST BIRTHDAY)   |    | IF UNDER 1 YEAR   |    | IF UNDER 24 HRS   |      |   |  |                              |  |
| M   |  | B  |                   | 7 15 08   |    | 72  |    | MONTHS  |    | DAYS  |      | HOURS MIN.                                      |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |    | 9. BALTIMORE CITY OR COUNTY OF DEATH  |    |   |    |   |      | MD.   |  |                              |  |
| N.C.  |  | USA  |                   |   |    | Baltimore City  |    |   |    |   |      |   |  |                              |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |    | 12b. KIND OF BUSINESS OR INDUSTRY   |    |   |    |   |      |   |  |                              |  |
| Baltimore   |  | Provident Hosp.  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| 13a. STATE  |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN   |    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |    | 13e. STREET ADDRESS   |    |   |      |   |  |                              |  |
| Md  |  |  |                   | Baltimore   |    |   |    | 3439 Chesell Ct.  |    |   |      |   |  |                              |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| Spencer   |  | Miller   |                   | Etha  |    | Perkin  |    |   |    |   |      |   |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT   |    | ADDRESS   |    |   |    |   |      |   |  |                              |  |
| NO  |  | 063-12-5704  |                   | PRIESTLY Thompson   |    | 595 E. 167th St.  |    |   |    |   |      |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:   |  |  |                   |   |    |   |    |   |    |   |      | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                              |  |
| 1539 IMMEDIATE CAUSE (a) CARCINOMA - Colonic  |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| 19a. DATE OF OPERATION  |  |  |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |    |   |    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |      |   |  |                              |  |
|   |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |    |   |    |   |      |   |  |                              |  |
|   |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |                   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |    |   |    |   |      |   |  |                              |  |
|   |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 09-23 19 80 to 10-11 19 80, that (I) (we) last saw the deceased alive on 10-11 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| 22b. SIGNATURE<br>M.A. Allen, M.D.  |  |  |                   |   |    |   |    |   |    |   |      | DEGREE  |  | 22c. DATE SIGNED<br>10-11-80 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M.A. Allen, M.D.   |  |  |                   |   |    |   |    |   |    |   |      | 22e. ADDRESS                                    |  |                              |  |
|   |  |  |                   |   |    |   |    |   |    |   |      |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  |                   | 23b. DATE   |    | 23c. NAME OF CEMETERY OR CREMATORY  |    |   |    | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |      |   |  |                              |  |
| Burial  |  |  |                   | 10/16/80  |    | Geo. Wash. Mem. Pk.   |    |   |    | Paramus, N.J.   |      |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  |                   |   |    | 25a. DATE REC'D. BY REGISTRAR   |    |   |    | 25b. REGISTRAR'S SIGNATURE  |      |   |  |                              |  |
| Wm C March F/H  |  |  |                   |   |    | 1101 E. North Ave.  |    |   |    | OCT 14 1980   |      |   |  |                              |  |

0. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 190 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 5 9 0 7  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELIZABETH THOMPSON</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>OCTOBER 14, 1980</b>  |  | 2b. HOUR<br><b>1:40AM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 30, 1914</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>66</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Harford Co., Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Sub. R.D. Postal Carr.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Harford</b>  |  | 13c. CITY OR TOWN<br><b>Havre de Grace</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Chester Allen DeBaugh</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Corra Mc Kinley DeBaugh</b>   |  | 13e. STREET ADDRESS<br><b>110 N. Earleton Road</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-38-0962</b>   |  | 17. INFORMANT ADDRESS<br><b>Leon S. Thompson Havre de Grace, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myelogenous Leukemia</b><br><b>2059</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Blast Crisis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Renal - Respiratory Failure</b>                                    |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 months</b><br><b>2 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/12</b> , 19 <b>80</b> , to <b>10/14</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/14</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Jeffrey Abrams</b>   |  |  |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jeffrey Abrams</b>  |  |  |  | 22e. ADDRESS<br><b>JHH 900 Wolfe St Balt, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Oct. 16, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wesleyan Chapel</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Harford County Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell Funeral Home</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barbara A. ...</b>  |  |

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FROM: [illegible]  
SUBJECT: [illegible]  
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a teletype message.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |               | REG. NO. 80 25908         |  |
|--|--|---|--|--|--|---|--|--|---------------|---------------------------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |   |  |  |               |                           |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>(RALPH) RAVAINELL-THOMPSON   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>October 6, 1980  |   |  |  | 2b. HOUR<br>M |                           |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 3 18  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |               | IF UNDER 24 HRS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                       |  |  |               |                           |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>419 Mt. Holly St. |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |               |                           |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>419 Mt. Holly St.   |               |                           |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Willie Thompson   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Exie Bryant  |   |  |  |               |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>212-32-0535   |  | 17 INFORMANT ADDRESS<br>Margaret S. Thompson 419 Mt. Holly St.   |  |   |  |  |               |                           |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <del>Respiratory Failure</del> Respiratory Failure<br>4039<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Renal Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Severe Hypertension<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |   |  |  |               |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Anemia   |  |   |  |  |  |   |  |  |               |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |               |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |               |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |               |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 28, 1980, to Oct 5, 1980, that (I) (we) last saw the deceased alive on October 5, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |  |  |  |   |  |  |               |                           |  |
| 22b. SIGNATURE<br>S. Johnson MD  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>10/7/80  |               |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S. Johnson MD   |  |   |  |  | 22e. ADDRESS<br>800 Bradleish Avenue Balto. MD 21216   |   |  |  |               |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/11/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Grove Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Forest City N.C.                                  |  |  |               |                           |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 7 1980  |   | 25b. REGISTRAR'S SIGNATURE<br>Fitzgerald |  |               |                           |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 25909

|  |  |                  |  |   |  |  |  |   |  |  |  |   |  |  |  |
|--|--|------------------|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Glen n  |  | MIDDLE<br>Thornton  |  | LAST<br>Thornton   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED  |  | XX MONTH DAY YEAR<br>10 30 80  |  | 2b. HOUR<br>M<br>10:30P   |  |  |  |
| 3. SEX<br>male   |  | 4. RACE<br>black |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>2 2 58  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>22 YRS.               |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>10 30 19 80            |  | 7d. HOUR<br>10:30P  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>201 E. North Avenue |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br>Maryland   |  |                  |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>201 E. North Avenue |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas H. Thornton   |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary E. Holley   |  |  |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-68-4270  |  |  |  | 17. INFORMANT ADDRESS<br>Mary E. Thornton 509 McCabe Avenue   |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Drowning</u><br>9104<br>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.<br>(b) _____<br>(c) _____  |  |                  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
|  |  |                  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br>Seizure disorder  |  |                  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>7:30PM 10/30/80  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>found in water of bath tub   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>house  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>201 E. North Avenue, Baltimore City  |  |  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Hormez R. Guard, M.D.  |  |                  |  | TITLE (SPECIFY)<br>Assistant  |  |  |  | MEDICAL EXAMINER  |  |  |  | DATE SIGNED<br>10/31/80   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Hormez R. Guard, M.D.  |  |                  |  | ADDRESS<br>111 Penn Street, Balto., MD 21201  |  |  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |  | 23b. DATE<br>11/3/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown, Maryland |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March Funeral Home, Inc./1101 E. North Ave.   |  |                  |  | ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>L. J. McBratney                        |  |   |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

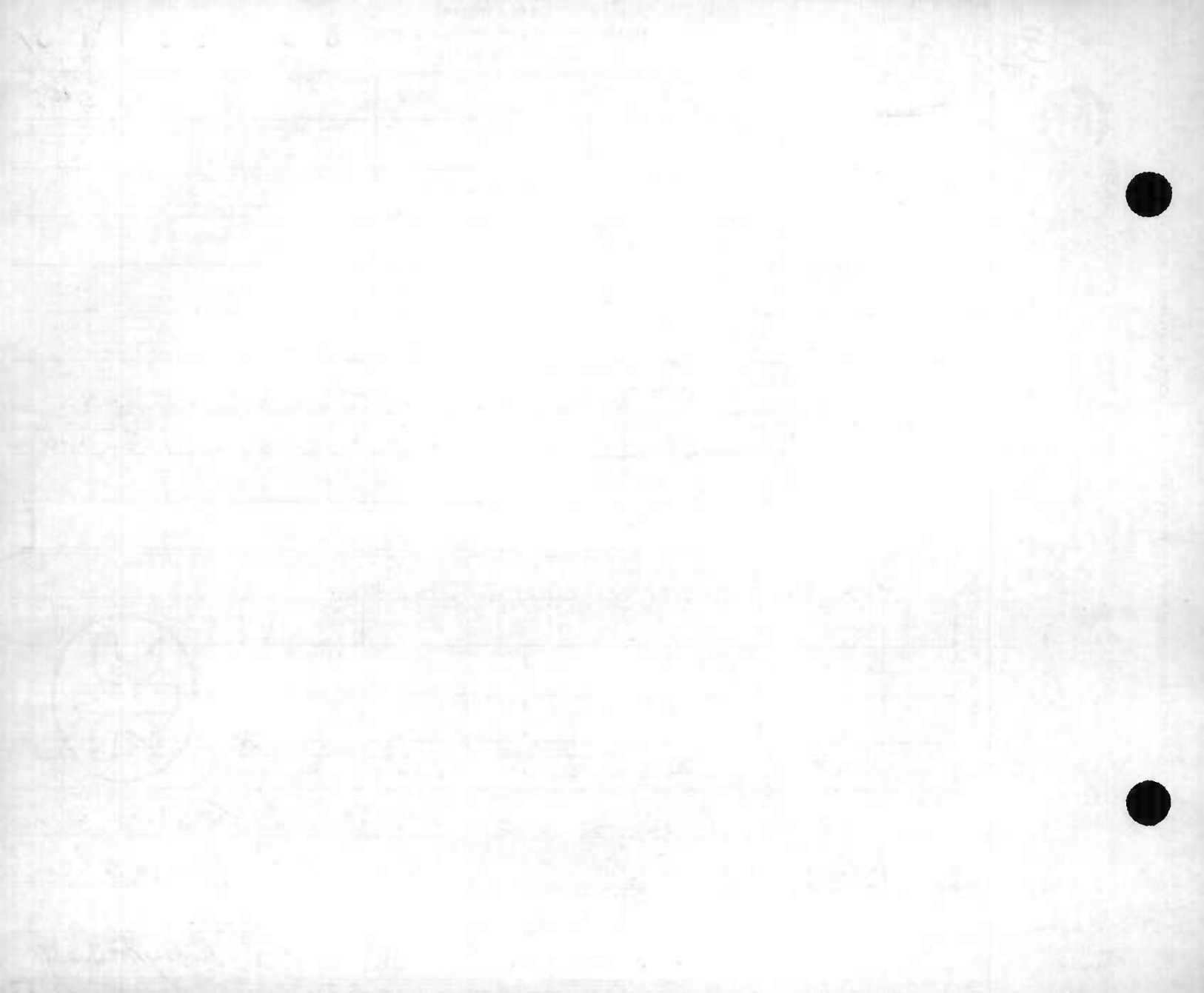
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 1 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |  |   |  |  |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Missie F. Thornton</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>10 20 80</i>                         |   |   | 2b. HOUR<br><i>4:40 AM</i>   |   |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>4 18 43</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>37</i> YRS                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>N.C.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Good Samaritan Hosp</i> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Md.</i>  |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><i>Balto.</i>                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br><i>1317 E. 35th Street</i>   |  |   |   |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Unkn</i>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lucille L. Thornton</i> |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  |   | 16b. SOCIAL SECURITY NO.<br><i>237-70-9260</i>                              |   | 17. INFORMANT<br>ADDRESS<br><i>William L. Thornton 1317 E. 35th St.</i> |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>Breast cancer with widespread metastases</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>1749</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <i>Rectal bleeding, thrombocytopenia, hypotension</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>one year</i>  |  |
| 19a. DATE OF OPERATION<br><i>—</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>—</i>  |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>— — — 19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>October 18, 19 80</i> to <i>Oct. 20, 19 80</i> , that (I) (we) last saw the deceased alive on <i>Oct 20, 19 80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Kenneth H C Silver</i>   |  |   |   | DEGREE<br><i>MD</i>   |   |  |   | 22c. DATE SIGNED<br><i>10/20/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Kenneth H C Silver</i>  |  |   |   | 22e. ADDRESS<br><i>832 Evesham Ave. Balto, Md 21212</i>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>10/26/80</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Elmwood Cemetery</i>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Goldsboro, N.C.</i>                 |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C March F/H</i>   |  |   |   | ADDRESS<br><i>1101 E. North Ave.</i>  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 20 1980</i>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Dorothy McCreedy</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the registrars, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 0 2 5 9 1 1<br>REG. NO.   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MALINDA THORTON   |  |   |  |
| 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 31, 1980   |  |  |  | 2b. HOUR<br>9:30 P.M.   |  |   |  |
| 3. SEX<br>F  |  | 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 - 5 - 07   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>73 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Balt.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION (TYPICAL WORK FOR MOST OF WORKING LIFE)<br>Domestic   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |  |  |  | 13b. COUNTY<br>BALTO.   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>7   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SUSIE BUGG5   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-03-1112A  |  | 17. INFORMANT ADDRESS<br>ORGIE Kimball  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CEREbroVASCULAR ACCIDENT<br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>AND ATRIAL FIBRILLATION.<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 MONTHS |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>-  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>-   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>-  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from AUGUST 13, 1980, to OCT. 31, 1980, that (I) (we) last saw the deceased alive on 10/31/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Amperham   |  |  |  | DEGREE<br>MB BCH  |  | 22c. DATE SIGNED<br>10/31/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALISON PELHAM   |  |  |  | 22e. ADDRESS<br>DEPT. MEDICINE, JOHNS HOPKINS HOSPITAL  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/5/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. CALVARY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>A.H. County Md  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Locks Funeral Home   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>Petrykel  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the registrars, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



11-11-11



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M/7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

\*FOR  
1- STATE  
REGISTRAR

|   |  |                  |   |   |  |   |  |   |   |  |  |
|---|--|------------------|---|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elaine Leona Timberlake   |  |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br>10 27 19 80   |   |  | 2b. HOUR<br>M<br>6:30P  |  |   |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 9, 1922 |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>58 YRS  |  | 7. IF UNDER 1 YR. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                     |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>469 S. Augusta Avenue |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br>Maryland  |  |                  | 13b. COUNTY   |   |  | 13c. CITY OR TOWN<br>Baltimore  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET ADDRESS<br>469 S. Augusta Ave.  |  |                  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Shaskey  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Galloway   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |                  | 16b. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT<br>ADDRESS<br>Howard L. Timberlake Same   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |   |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22. I certify that I took charge of the remains described above, held on death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                  |   |   |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.   |  |                  | TITLE (SPECIFY)<br>Deputy Chief MEDICAL EXAMINER  |   |  |   |  |   | DATE SIGNED<br>10/28/80   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  |                  | ADDRESS<br>111 Penn St. Balto., MD.   |   |  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  | 23b. DATE<br>Oct. 31, 1980  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Olivet  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City Maryland                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mitchell-Wiedefeld Home, Inc. Baltimore, Md.  |  |                  | ADDRESS<br>6560 York Rd.  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 31 1980  |  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 0 2 5 9 1 3   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARTHA L. TODD</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>2</b> YEAR <b>1980</b>  |  | 2b. HOUR<br><b>11:45 P.M.</b>  |  |
| 3 SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>DEC.</b> DAY <b>4</b> YEAR <b>1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TEACHER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PUBLIC SCHOOL</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3900 N. CHARLES ST.</b>  |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>WILLIAM</b> MIDDLE <b>R.</b> LAST <b>LYNCH</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>SARAH</b> MIDDLE <b>GRACE</b> LAST <b>GRACE</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-38-5924</b>   |  | 17. INFORMANT ADDRESS<br><b>MARY E. GRIFFITHS R.D. 1 WERNERSVILL, PA. 19565</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b><br><b>1749</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bilateral pleural effusions</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Metastatic Breast Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/18</b> , 19 <b>80</b> , to <b>10/2</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James Ruppel MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10/2/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Ruppel</b>   |  |   |  | 22e. ADDRESS<br><b>Union Memorial Hospital</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>OCT. 6, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>TODD INHERITANCE CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>FT. HOWARD</b> COUNTY <b>MD.</b> STATE <b>MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>MITCHELL-WIEDEFELD HOME</b> ADDRESS <b>6500 YORK RD.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |  |   |  |  |  |
|--|--|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Beatrice Tongue</b>  |  |  |   |  | 2a. DATE OF DEATH MONTH <b>10</b> DAY <b>10</b> YEAR <b>80</b> 2b. HOUR <b>9:30</b> AM       |   |  |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>Black</b>   |   | 5. DATE OF BIRTH MONTH <b>8</b> DAY <b>15</b> YEAR <b>09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.                                    |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, City</b> MD.                   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Balt. City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lincoln Conv. Center</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>A.A.</b>  |   | 13c. CITY OR TOWN <b>Edgewater</b>   |  | 13e. STREET ADDRESS <b>473 Mayo Road, Edgewater Md.</b>                           |  |  |  |
| 14. FATHER'S NAME FIRST <b>RICHARD</b> MIDDLE <b></b> LAST <b>BROWN</b>  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>ELEANOR</b> MIDDLE <b></b> LAST <b>PETERS</b>              |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>216-32-7392</b>  |   | 17. INFORMANT ADDRESS <b>SAMUEL TONGUE 473 Mayo Rd. Edgewater, Md.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Vascular Collapse, Acute</b><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASCVD &amp; hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 19, 1978</b> to <b>Oct 10, 1980</b> , that (I) (we) last saw the deceased alive on <b>Oct 9, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE <b>A. Baykaler, M.D.</b> DEGREE <b></b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   |  |  | 22c. DATE SIGNED <b>10-10-80</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. BAYKALER, M.D.</b>   |  |  |   |  |  | 22e. ADDRESS <b>3459 St. Johns Lane, Edgemoor City Md.</b>                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  |  |  | 23b. DATE <b>10-13-1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HOPES CHURCH CEME.</b>                                 |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Edgewater A.A. Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR NAME <b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b> ADDRESS <b>Annapolis, Md.</b>   |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1980</b>                                  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

REPORT FROM THE DIRECTOR OF THE BUREAU OF THE CENSUS

ON THE RESULTS OF THE CENSUS OF 1900

IN THE DISTRICT OF COLUMBIA

BY THE DIRECTOR OF THE BUREAU OF THE CENSUS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |  |   |  |   |  | 8  | 0 | 2   | 5   | 9                                      | 1 | 5 |
|---|--|--|--|--|--|---|--|---|--|--|---|---|---|--|---|---|
| FOR<br>STATE<br>REGISTRAR   |  |  |  |  |  |   |  |   |  | REG. NO.   |   |   |   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Rezen Travers  |  |  |  |  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/1/80   |   |   |   | 2b. HOUR<br>12:20 AM                   |   |   |
| 3 SEX<br>Male   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 7 1898  |  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                 |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS              |   | IF UNDER 24 HRS.<br>HOURS MIN.         |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD. |  |   |   |   |  |   |   |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mfg of Bed Sprgs   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Foster Bros. |  |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |   |  |   |  |  |   |   |   |  |   |   |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore                           |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4726 Ivanhoe Ave.   |   |   |   |  |   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>unknown  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>unknown |   |  |   |  |  |   |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 09 0859   |  |  | 17 INFORMANT<br>ADDRESS<br>family   |  |   |  |  |   |   |   |  |   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br><u>4275</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arrhythmia; Cerebral vascular Accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |   |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><u>Hypertension</u>  |  |  |  |  |  |   |  |   |  |  |   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |   |   |   |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |   |   |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |   |   |  |   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept 19</u> , 19 <u>80</u> , to <u>Oct 1</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>Oct 1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |   |  |  |   |   |   |  |   |   |
| 22b. SIGNATURE<br>Ann E Duerr, MD   |  |  |  |  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>10/1/80                 |   |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ann E Duerr, MD  |  |  |  |  | 22e. ADDRESS<br>UNION MEMORIAL HOSPITAL                  |   |  |   |  |  |   |   |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  |  | 23b. DATE<br>10/4/1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Carroll Chapel     |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. County, Md.                                |  |  |   |   |   |  |   |   |
| 24 FUNERAL DIRECTOR<br>NAME<br>EVANS FUNERAL CHAPEL   |  |  |  |  |  |   |  |   |  | ADDRESS<br>8802 Harford Rd   |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 6 1980 |   | 25b. REGISTRAR'S SIGNATURE<br>Dietrich |   |   |



UNITED STATES

UNITED STATES

UNITED STATES

RECEIVED OCT 10 1980

UNITED STATES

0891 3 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner would be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |        |   |                   |   |       | REG. NO. 8025916                  |      |          |
|---|--|--|--|---|--------|---|-------------------|---|-------|-----------------------------------|------|----------|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST   | MIDDLE | LAST  | 2a. DATE OF DEATH |   | MONTH | DAY                               | YEAR | 2b. HOUR |
|   |  | HERMAN HENRY TREFF JR.   |  |   |        |   | 10 23 1980        |   |       |                                   |      | 11:00AM  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |        | 6. AGE (IN YEARS LAST BIRTHDAY)                                   |                   | IF UNDER 1 YEAR   |       | IF UNDER 24 HRS                   |      |          |
| MALE  |  | WHITE  |  | MONTH DAY YEAR<br>1 8 1913  |        | 67 YRS  |                   | MONTHS DAYS   |       | HOURS MIN.                        |      |          |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9. BALTIMORE CITY OR COUNTY OF DEATH                              |                   |   |       |                                   |      |          |
| MARYLAND  |  | U S A  |  |   |        | BALTIMORE CITY MD   |                   |   |       |                                   |      |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |        |   |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |       | 12b. KIND OF BUSINESS OR INDUSTRY |      |          |
| BALTIMORE   |  | VAMC LOCH RAVEN, BALTIMORE, MD   |  |   |        |   |                   | Plumber   |       | Local #48                         |      |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13b. STATE  |        | 13c. CITY OR TOWN   |                   | 13e. STREET ADDRESS   |       |                                   |      |          |
| MARYLAND  |  |  |  | Baltimore   |        | BALTIMORE   |                   | 2920 PENNSYLVANIA AVENUE 21227                                |       |                                   |      |          |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |        |   |                   |   |       |                                   |      |          |
| Herman  |  |  |  | Treff, Sr.  |        | Florence Holmes   |                   |   |       |                                   |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |                   |   |       |                                   |      |          |
| YES   |  |  |  | W W II 218 05 7324  |        | Mrs. Frances C. Treff 2920 Pennsylvania Ave. Baltimore, Md. 21227 |                   |   |       |                                   |      |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  |  |  |   |        |   |                   |   |       |                                   |      |          |
| 5325 IMMEDIATE CAUSE (a) <u>Unstable Angina -&gt; Cardiac Arrest</u>  |  |  |  |   |        |   |                   |   |       |                                   |      |          |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable MI</u>   |  |  |  |   |        |   |                   |   |       |                                   |      |          |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Shed part of chronic illness</u>  |  |  |  |   |        |   |                   |   |       |                                   |      |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Congestive heart failure, chronic renal failure</u>  |  |  |  |   |        |   |                   |   |       |                                   |      |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?    |                   |   |       |                                   |      |          |
| 10/22   |  | Perforated duodenum  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |        | YES <input type="checkbox"/> NO <input type="checkbox"/>          |                   |   |       |                                   |      |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |        |   |                   |   |       |                                   |      |          |
|   |  | P.M. 19  |  |   |        |   |                   |   |       |                                   |      |          |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |        |   |                   |   |       |                                   |      |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET  |        | CITY OR TOWN  |                   | COUNTY  |       | STATE                             |      |          |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 22</u> , 19 <u>80</u> , to <u>OCTOBER 23</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>OCTOBER 23</u> , 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |        |   |                   |   |       |                                   |      |          |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |        | 22c. DATE SIGNED  |                   |   |       |                                   |      |          |
| Thomas O'Dowd   |  | MD   |  |   |        | 10/23   |                   |   |       |                                   |      |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |        |   |                   |   |       |                                   |      |          |
| Thomas O'Dowd   |  | Johns Hopkins Hospital   |  |   |        |   |                   |   |       |                                   |      |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |        | 23d. LOCATION   |                   |   |       |                                   |      |          |
| Burial  |  | 10/27/80   |  | Loudon Park Cemetery  |        | Baltimore   |                   | MD.   |       |                                   |      |          |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |        | 25b. REGISTRAR'S SIGNATURE  |                   |   |       |                                   |      |          |
| Mc Cutty Funeral Home of Brooklyn<br>237 E. Patapsco Avenue Baltimore, Md. 21225  |  |  |  | OCT 24 1980   |        | R. J. [Signature]   |                   |   |       |                                   |      |          |



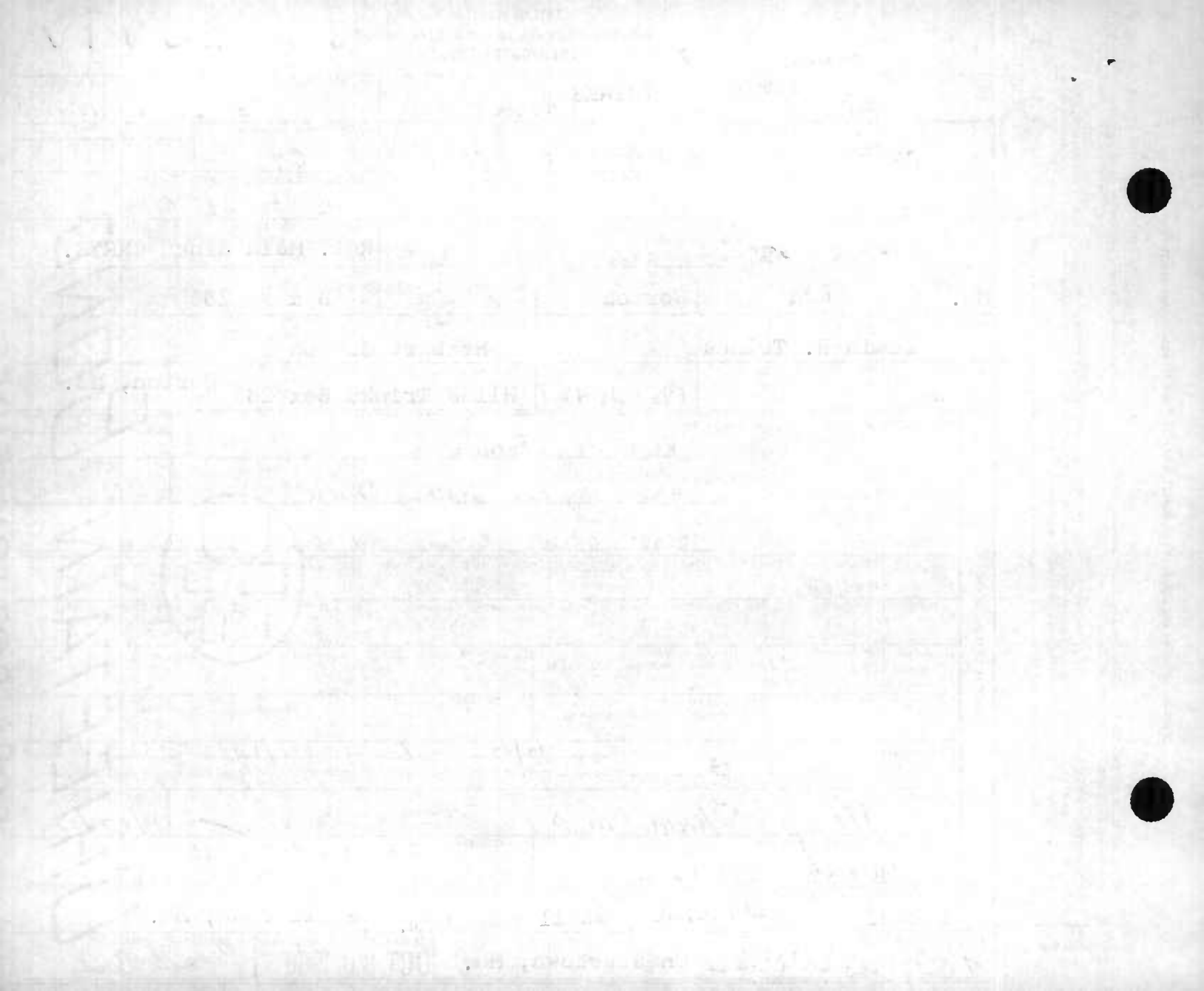
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  | 80       | 25917 |
|---|--|--|--|---|--|---|--|--|--|----------|-------|
| 1- FOR STATE REGISTRAR <i>CDUN R.</i>   |  |  |  |   |  |   |  |  |  | REG. NO. |       |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <i>Edwin R. TRINKS</i>   |  |  |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR <i>10 27 80</i>  |  | 2b HOUR<br><i>10:45 (M)</i>  |  |          |       |
| 3 SEX<br><i>male</i>  |  | 4 RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>1 29 11</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>69</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |          |       |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore</i>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                                |  |  |  |          |       |
| 10 CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Baltimore Cancer Research Center</i> |  |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Ret. Maintaine</i>        |  | 12b KIND OF BUSINESS OR INDUSTRY<br><i>CHRS.</i>   |  |          |       |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>Kent</i>   |  | 13c. CITY OR TOWN<br><i>Worton</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>Box # 285</i>  |  |          |       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Edwin H. Trink</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Herbert Sutton</i>  |  |   |  |  |  |          |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>no</i>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>196-26-4717</i>  |  | 17. INFORMANT ADDRESS<br><i>Hilda Trink</i> <i>Box 285 Worton, Md.</i>                          |  |  |  |          |       |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Respiratory Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Gram Negative Septic Shock</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Blast Crises - Chronic Myelogenous Leukemia</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |          |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><i>Diabetes</i>   |  |  |  |   |  |   |  |  |  |          |       |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |          |       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |          |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/14</i> , 19 <i>80</i> , to <i>10/27</i> , 19 <i>80</i> , that (I) (we) lost<br>saw the deceased alive on <i>10/27</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.       |  |  |  |   |  |   |  |  |  |          |       |
| 22b. SIGNATURE<br><i>Henry Gerd, M.D.</i>   |  |  |  | DEGREE<br><i>M.D.</i>   |  |   |  | 22c. DATE SIGNED<br><i>10/27/80</i>  |  |          |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>HENRY GERD, M.D.</i>  |  |  |  | 22e. ADDRESS<br><i>22. S. Greene St. Baltimore Cancer Research Center</i>   |  |   |  |  |  |          |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>10/30/80</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Still Pond Cem.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Still Pond, Md.</i>                            |  |  |  |          |       |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Willis Wells</i>   |  |  |  | ADDRESS<br><i>Chestertown, Md.</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 30 1980</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Henry Gerd</i>  |  |          |       |



DHMH: 16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

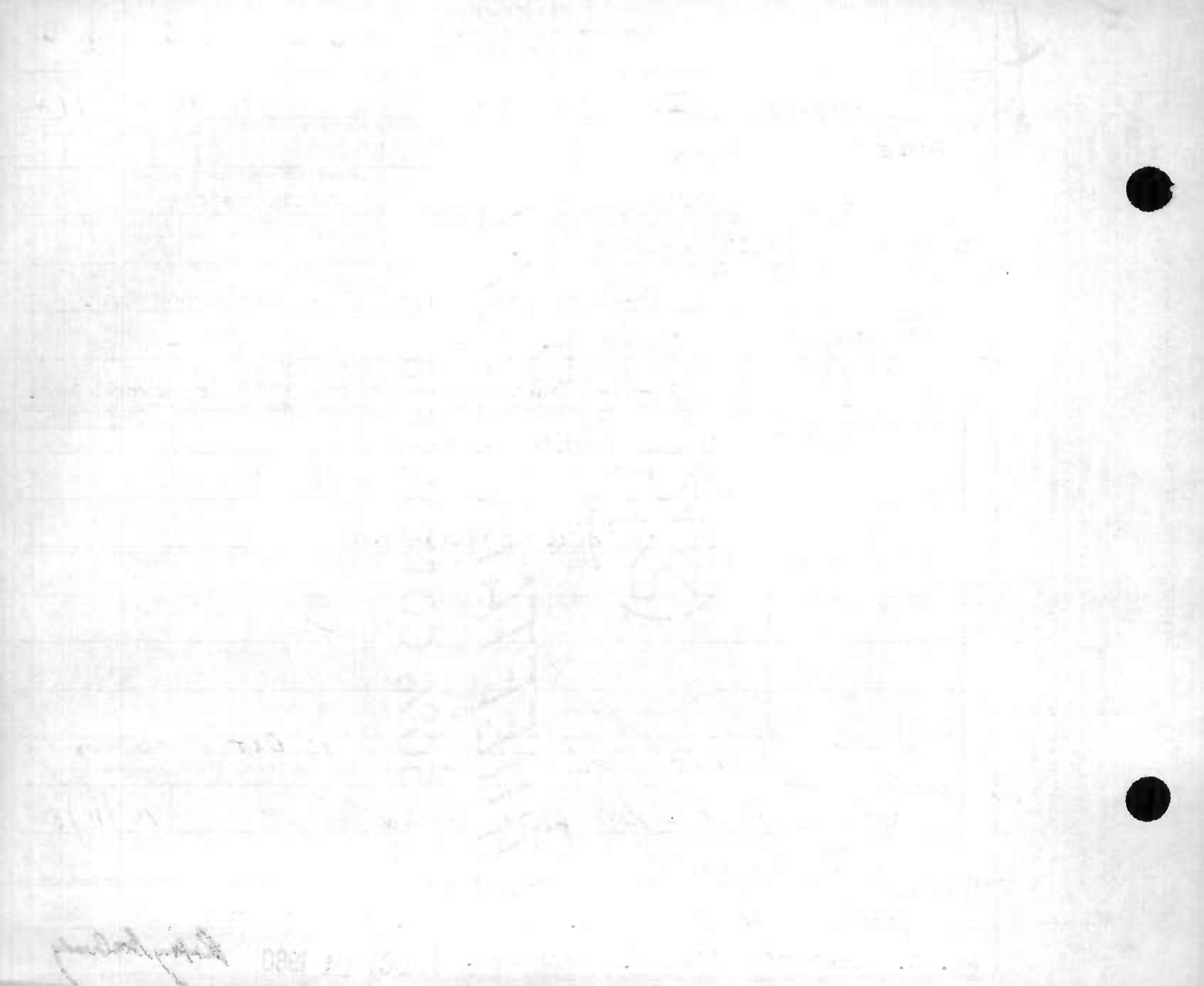
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 0 2 5 9 1 8   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |   |  |
| FIRST MIDDLE LAST   |  |  |  | MONTH DAY YEAR HOUR   |  |   |  |
| CHARLES I. TRUSTY   |  |  |  | 10 10 80 11 A.M.  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| MALE  |  | BLACK  |  | MONTH DAY YEAR  |  | 72 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| MD  |  | USA  |  |   |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore   |  | 1018 Brentwood Ave.  |  |   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| MD  |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS   |  |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | 1018 Brentwood Ave.   |  |   |  |
| Charles   |  | Trusty Jr.   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |
| UNK   |  | 217-01-1657  |  | Catherine Monroe  |  | 1019 Brentwood Ave.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |
| (b) <u>1991</u>   |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |
| (c) <u>SMALL CELL CARCINOMA</u>   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 MAY</u> , 19 <u>80</u> , to <u>10 OCT</u> , 19 <u>80</u> , that (we) lost<br>saw the deceased alive on <u>9 OCT</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |
| <u>George D. Parker MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 10/11/80  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |
| A. B. GROLTHOW  |  | 600 N. WOLFE STREET  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial  |  | 10/15/80   |  | Mt. Auburn Cem.   |  | Baltimore MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Wm. C. March F/H  |  | 1101 E. North Ave.   |  | OCT 14 1980   |  | <u>Anthony McBrady</u>  |  |

MEDICAL CERTIFICATION

19

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1- STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                      |  | 8 0 2 5 9 1 9   |  |
| FOR   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
| Edna Ruth Trusty  |  | October 14, 1980  |  | 1:15P M   |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |
| Female  |  | Negro   |  | 2 5 25  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| MD  |  | USA   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Baltimore City  |  | Maryland General Hospital   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  |
| MD  |  |   |  | Baltimore   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  | 16. STREET ADDRESS  |  |
|   |  |   |  | 1018 Brentwood Ave.   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |
| No  |  | 216-20-7878   |  | Edna R. Trusty 1018 Brentwood Ave.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of right Lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>October 3</u> 19 <u>80</u> , to <u>October 14</u> 19 <u>80</u> , that (X) (we) lost <u>the deceased</u> above, (X) (we) (did) <u>not</u> view the body after death.                     |  | 22b. SIGNATURE<br><u>Eric Fisher</u><br>DEGREE <u>MD</u>  |  | 22c. DATE SIGNED<br><u>10/15/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Eric Fisher, M.D.  |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/21/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 17 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |



University of Maryland Medical Center

Department of Plastic Surgery

Page 1

Dr. [Name] [Address]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 9 2 0

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Viola Tucker</i>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 12 80</i>  |   | 2b. HOUR<br><i>7:25 AM</i>                          |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>Black</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>06 06 11</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>69</i> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>DUNWIDDIE CO VA</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.   |   |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>JOHN DEATON Med. CTR.</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWORK</i>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>at home</i> |
| 13a. STATE<br><i>MD</i>   | 13b. COUNTY<br><i>MD</i>  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>3837 BOEHLER AVE</i>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Samuel A STAGAT</i>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>M. NERVA MARK</i>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>   |   | 16b. SOCIAL SECURITY NO.<br><i>204-20-2776</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>CLIFTON STAGAT 3837 BOEHLER AVE</i>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Malignant hypertension</i><br><i>436-</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <i>Totemic CVA</i><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF                   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <i>80</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May 1</i> , 19 <i>80</i> , to <i>Oct. 12</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>Oct. 12</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br><i>Julian W. Reed M.D.</i>  |   | DEGREE  |   | 22c. DATE SIGNED<br><i>10/14/80</i>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>JULIAN W. REED M.D.</i>   |   | 22e. ADDRESS<br><i>511 S. CHAS ST 21230</i>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><i>Home</i>   |   | 23b. DATE<br><i>10/13/80</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>FLORIAN OAK</i>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>DUNWIDDIE CO VA</i>  |   |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>M. W. Wynn</i>   |   | 24b. ADDRESS<br><i>638 N. BILMOR ST</i>   |   | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 14 1980</i>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Patricia Kelly</i>   |   |   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 of this form should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO  
LIBRARY



UNIVERSITY OF CHICAGO

LIBRARY

1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 50M 1/76  
(VR A 15 (4))

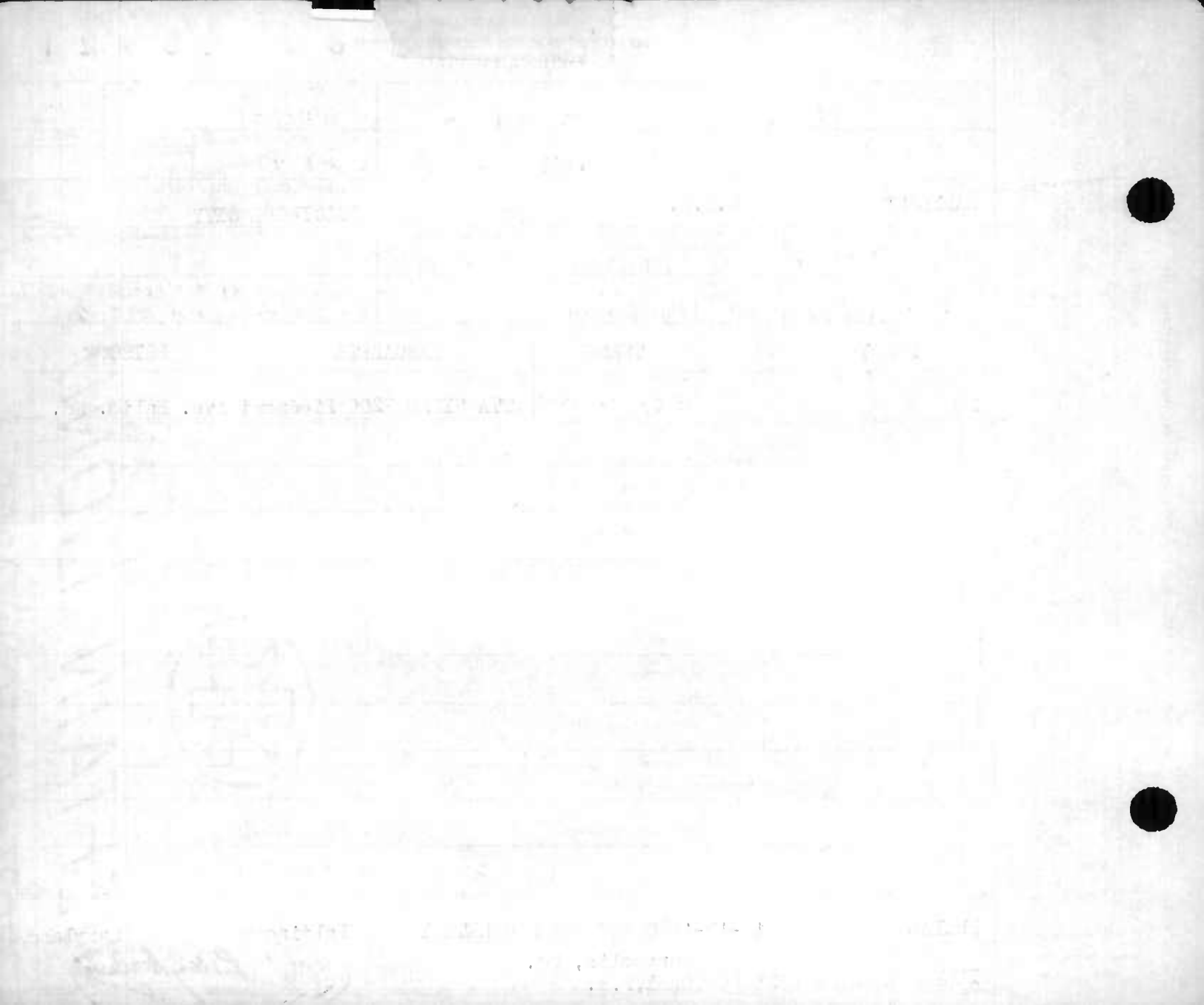
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |  |  |  |  |  |  | 8 0 2 5 9 2 1  |  |  |  |                                      |  |
|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--------------------------------------|--|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |   |  | CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |  |  |                                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | FIRST MIDDLE LAST  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  |  |  | 2b. HOUR   |  |                                      |  |
| charles  |  |   |  | TURNER   |  |  |  | 10/10/80   |  |  |  | 5:15 AM  |  |                                      |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |  |  |                                      |  |
| MALE   |  | Black   |  | MONTH DAY YEAR   |  | 40 yrs   |  | MONTHS DAYS  |  | HOURS MIN  |  |  |  |                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |  |  |                                      |  |
| MARYLAND   |  | U.S.A.  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | BALTIMORE CITY MD.   |  |  |  |  |  |  |  |                                      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |                                      |  |
| BALTIMORE  |  | GOOD SAMARITAN HOSPITAL   |  |  |  |  |  |  |  |  |  |  |  |                                      |  |
| 13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS                  |  |
| BALTIMORE  |  |   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 202 Heedbery Ct, Baltimore, Md 21206 |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |                                      |  |
| PERRY  |  |   |  | TURNER   |  |  |  | MARGARETE BRISCOE  |  |  |  |  |  |                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |  |  |                                      |  |
| NO   |  |   |  | 220-36-4219  |  | ETTA SIMMS 3200 Piedmont Ave. Balto. Md.                                       |  |  |  |  |  |  |  |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-respiratory<br>585-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) chronic renal failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |  |  |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |  |  |  |  |  |  |  |  |                                      |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                                      |  |
|  |  |   |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |  |  |                                      |  |
|  |  |   |  | P.M. 19  |  |  |  |  |  |  |  |  |  |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN   |  | COUNTY STATE   |  |  |  |                                      |  |
|  |  |   |  |  |  |  |  |  |  |  |  |  |  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10/80 to 10/10/80, that (I) (we) lost<br>saw the deceased alive on 10/10/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |  |  |  |  |  |  |                                      |  |
| 22b. SIGNATURE   |  |   |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |                                      |  |
| Sireesh Tripuraneni MD   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 10/10/80   |  |  |  |  |  |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |                                      |  |
| SIREESH TRIPURANENI  |  |   |  | GOOD SAMARITAN HOSPITAL, Baltimore, Md.  |  |  |  |  |  |  |  |  |  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN                                    |  | COUNTY STATE   |  |  |  |                                      |  |
| BURIAL   |  |   |  | 10-17-1980   |  | WOODLAWN CEMETERY  |  | Baltimore  |  | Maryland   |  |  |  |                                      |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |  | Annapolis, Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                    |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |                                      |  |
| WILLIAM REESE & SONS MORTUARY, P.A.  |  |   |  |  |  |  |  | OCT 16 1980  |  | L. J. Kelly  |  |  |  |                                      |  |

MEDICAL CERTIFICATION

9  
9

1

0501 BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 2 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

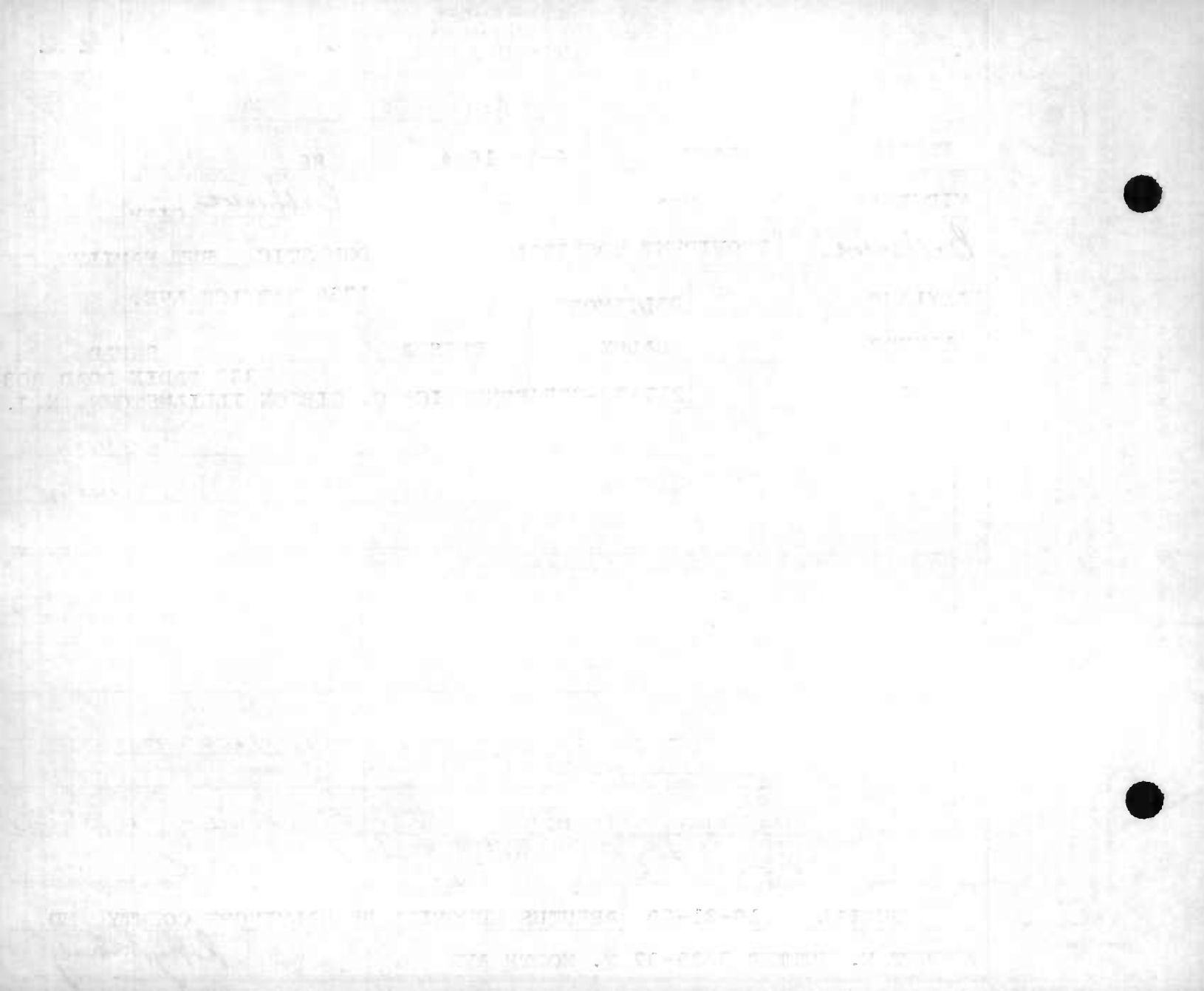
|   |  |  |   |   |
|---|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Violet</b>  |  | 2a DATE OF DEATH<br>MONTH <b>10</b> DAY <b>26</b> YEAR <b>80</b>   |   | 2b HOUR<br><b>11<sup>55</sup></b> P. M.   |
| 3 SEX<br><b>FEMALE</b>  | 4 RACE<br><b>BLACK</b>   | 5 DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>8</b> YEAR <b>1894</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>DAYS<br>HOURS<br>MIN.            |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> CITY MD.  |   |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PROVIDENT HOSPITAL</b> | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DOMESTIC</b>   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>PVT FAMILY</b>   |   |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               | 14. STREET ADDRESS<br><b>1738 WARWICK AVE.</b>                                    |
| 14 FATHER'S NAME<br>FIRST <b>ALFRED</b> MIDDLE LAST <b>HALEY</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ELISHA</b> MIDDLE LAST <b>SNEAD</b>   |  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  | 16b SOCIAL SECURITY NO.<br><b>217-38-7774</b>  | 17. INFORMANT<br>ADDRESS <b>338 RADIX ROAD RD3</b><br><b>FREDERICK C. GIBSON WILLIAMSTOWN, N.J.</b>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis &amp; Dehydration</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Bladder infection</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Chromosomal abnormality</b>   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>1 week</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Chromosomal abnormality</b>  |  |  |   |   |
| 19a DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/26</b> , 19 <b>80</b> , to <b>10/26</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/26</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |
| 22b. SIGNATURE<br><b>B. Shalovitz M.D.</b>  | DEGREE<br><b>SHABAZZ</b>   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                 | 22c. DATE SIGNED<br><b>10/27/80</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SHABAZZ</b>   | 22e. ADDRESS<br><b>Provident Hospital</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>10-31-80</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PK</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY, MD.</b>  |   |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>HERBERT E. NUTTER</b>   | ADDRESS<br><b>3035-37 W. NORTH AVE</b>   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1980</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McBrady</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

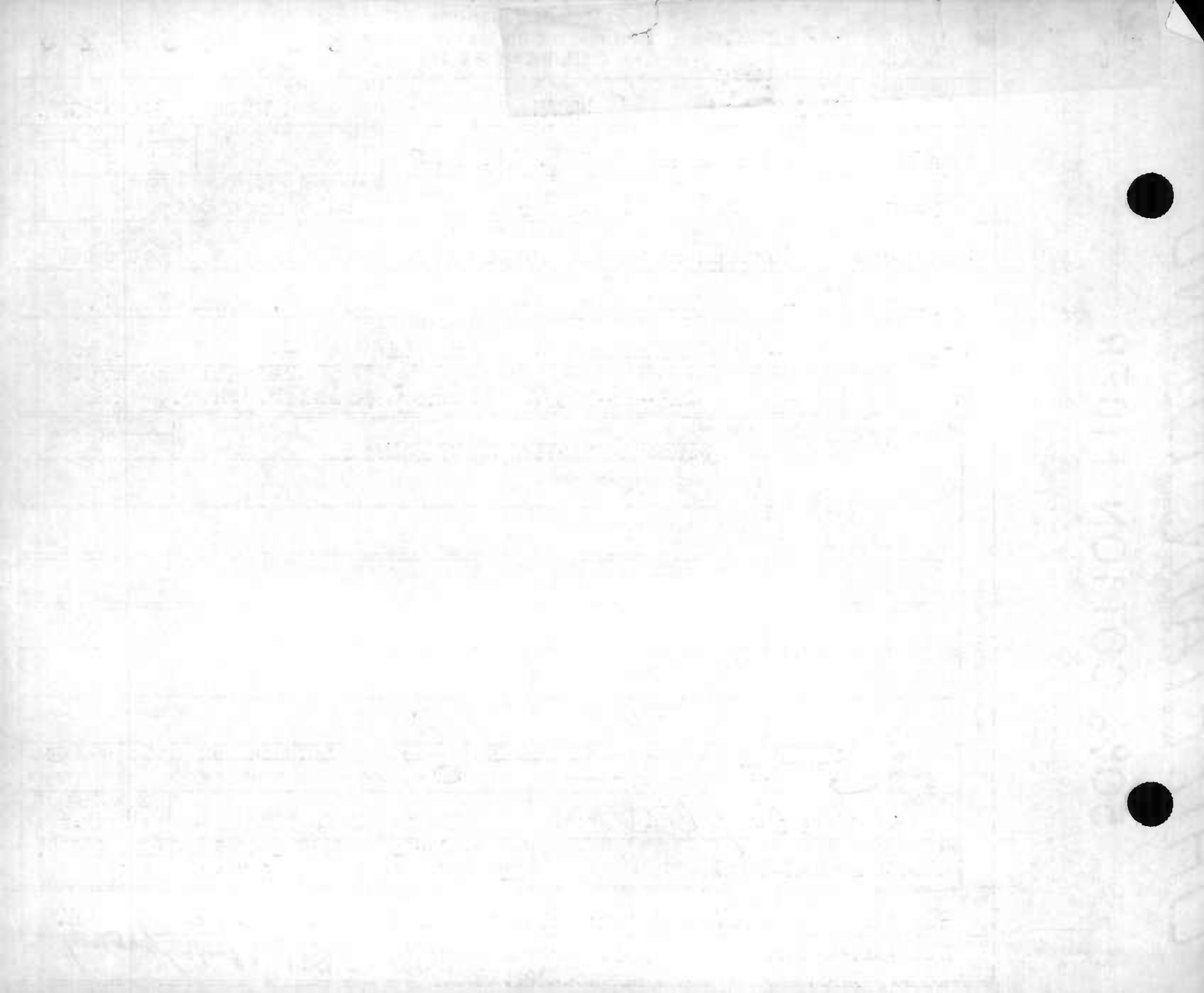
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 2 3

REG. NO.

|  |  |  |   |  |                                   |
|--|--|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | MONTH DAY YEAR   |   | HOURS MIN.   |                                   |
| FIRST MIDDLE LAST<br>HILDA URBAN   |  | OCTOBER 25, 1980   |   | 6:30A. M.  |                                   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 8. IF UNDER 1 YEAR   |                                   |
| Female   | Caucasian  | MONTH DAY YEAR<br>Dec. 14, 1897  | 82  | IF UNDER 24 HRS.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |
| Maryland   | USA  |  | Baltimore City MD   |  |                                   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore  | Church Hospital Corporation  |  | Saleslady   |  | Retail                            |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS               |
| Maryland   | -  | Baltimore  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2905 E. Monument St.   |                                   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |
| FIRST MIDDLE LAST<br>Anton - Neuman  |  | FIRST MIDDLE LAST<br>Josephine - Doyas   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |                                   |
| No -   |  | 219-16-3093A   |   | 6241 Hilltop Ave. Eleanor Marsalek, dghtr., 21206  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) SEVERE CONGESTIVE HEART FAILURE<br>4280<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   |
|  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | OCTOBER 20, 1980   |   | to OCTOBER 25, 1980, that (I) (we) last saw the deceased alive on OCTOBER 25, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |                                   |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |                                   |
| WALKER IMPAGLIATELLI, MD   |  |  |   | OCTOBER 25, 1980   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |                                   |
| WALKER IMPAGLIATELLI, MD   |  | CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| Burial   |  | 10/28/80   |   | Bohemian National  |                                   |
| 23d. LOCATION  |  | 23e. DATE REC'D. BY REGISTRAR  |   | 23f. REGISTRAR'S SIGNATURE   |                                   |
| Baltimore, Md.   |  | OCT 28 1980  |   | [Signature]  |                                   |
| 24. FUNERAL DIRECTOR   |  | 24b. ADDRESS   |   |  |                                   |
| Schimunek Funeral Home, Inc.   |  | 3331 Brehms Lane, Balto., Md. 21213  |   |  |                                   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                  |  |  |  |
|---|--|--|--|--|--|---|--|----------------------------------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 8 0 2 5 9 2 4  |  |  |  |   |  |                                  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR |  | 2b. HOUR                                     |  |
| (DR.)   |  | MERRILL  |  | F.   |  | UNGER   |  | OCTOBER 14, 1980                 |  | 05:18 AM                                     |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                  |  | IF UNDER 24 HRS                              |  |
| FEMALE  |  | WHITE  |  | MONTH 7 YEAR 16 DAY 09   |  | 71  |  | MONTHS                           |  | DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                  |  |  |  |
| MARYLAND  |  | U.S.A.   |  |  |  | BALTIMORE CITY  |  |                                  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                  |  |  |  |
| BALTIMORE   |  | THE JOHNS HOPKINS HOSPITAL   |  | MINISTER   |  | ---   |  |                                  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS              |  |  |  |
| MARYLAND  |  | ANNE ARUNDEL   |  | SEVERNA PARK   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 194 IVERNESS ROAD                |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                                  |  |  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |  |  |   |  |                                  |  |  |  |
| DR. MERRILL F. UNGER  |  | CATHERINE LEISTNER   |  |  |  |   |  |                                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS   |  |                                  |  |  |  |
| NO  |  | ---  |  | 463-52-8971  |  | SHELLY A. LAMPLUGH 248 RIVERDALE ROAD                               |  |                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>sepsis</u><br>3229<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>meningitis</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  |                                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |                                  |  |  |  |
| (R) cerebellar hemorrhagic infarct  |  |  |  |  |  |   |  |                                  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                  |  |  |  |
| 1 Oct 80  |  | Rt acoustic neuroma  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                  |  |  |  |
|   |  | P.M. 19  |  |  |  |   |  |                                  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY                           |  | STATE  |  |
|   |  |  |  |  |  |   |  |                                  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4 Oct</u> 19 <u>80</u> , to <u>14 Oct</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>14 Oct</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |  |  |   |  |                                  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |                                  |  |  |  |
| <u>G.B. Vogelsang MD</u>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 14 Oct 80  |  |   |  |                                  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                                  |  |  |  |
| G.B. Vogelsang MD   |  | Johns Hopkins Hosp. Baltimore  |  |  |  |   |  |                                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY                           |  | STATE  |  |
| BURIAL  |  | 10/18/80   |  | LOUDON PARK MAUSOLEUM  |  | BALTIMORE   |  |                                  |  | MD.  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                  |  |  |  |
| HUBBARD FUNERAL HOME 4107 WILKENS AVE.  |  | OCT 20 1980  |  | <u>Jeffrey Hebrandy</u>  |  |   |  |                                  |  |  |  |

BP

2017 NOV 100 540

DCI 5 0 1580

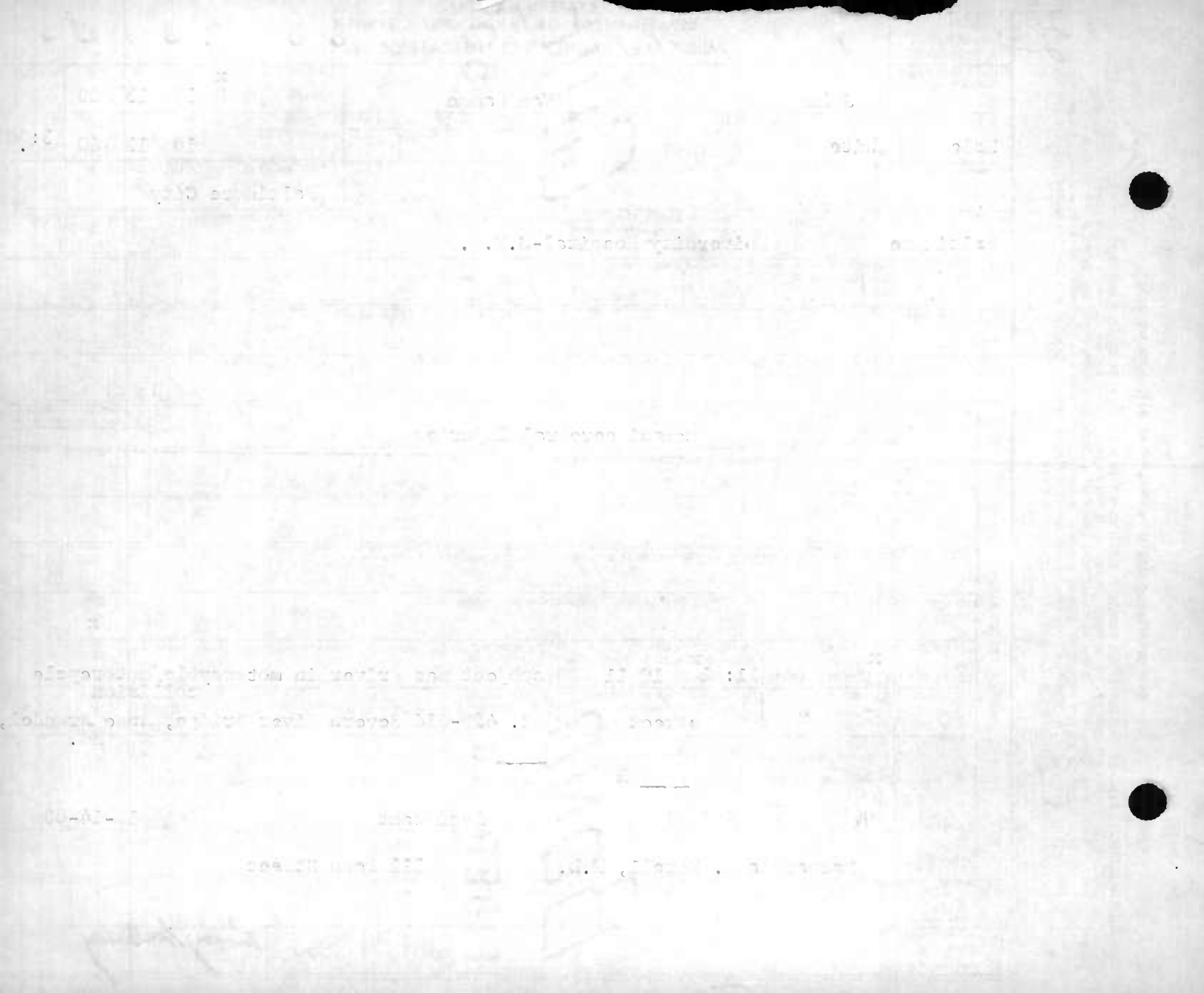
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(V) A15 ME (5)  
15M 7/76

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |               |  |  |  |   |  |  |  | REG. NO. 25925   |  |
|--|--|---------------|--|--|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR   |  |               |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) Jon Orville Van Damme  |  |               |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 13 1980                                  |  | 2b. HOUR M 3:00  |  |  |  |
| 3. SEX Male  |  | 4. RACE White |  | 5. DATE OF BIRTH MONTH DAY YEAR 4/24/51  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 29 YRS.   |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7c. DATE PRONOUNCED DEAD 10 13 1980  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Milwaukee Wisco.   |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.                          |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital-S.T.U. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mechanic   |  | 12b. KIND OF BUSINESS OR INDUSTRY automobile                                     |  |
| 13a. STATE Md.   |  |               |  | 13b. COUNTY A.A. Co/   |  | 13c. CITY OR TOWN Edgewater   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS 320 Londontown Rd.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Orville John Van Damme   |  |               |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Mildred Magnuson  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes   |  |               |  | 16b. SOCIAL SECURITY NO. 71-74   |  | 17. INFORMANT ADDRESS Josephine Sullivan same as 13 e.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Craniocerebral Injuries</b><br>8/22 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. }<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  |               |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |               |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |               |  | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 11:01 AM 10 11 1980   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was driver in motorcycle/motorcycle collision |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 450-Old Severn River Bridge, Anne Arundel, Md.                                   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |               |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i>  |  |               |  | TITLE (SPECIFY) Assistant MEDICAL EXAMINER   |  |   |  | DATE SIGNED 10-14-80   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.  |  |               |  | ADDRESS 111 Penn Street  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE 10-16, 1980  |  | 23c. NAME OF CEMETERY OR CREMATORY Cheltenham VA Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME Hardesty Funeral Home  |  |               |  | ADDRESS 12 Ridgely Ave, Ann. Md.   |  | 25. DATE REC'D BY REGISTRAR 10/21/1980  |  | SIGNATURE <i>Margarita A. Korell</i>   |  |  |  |



Vaughan  
86 of  
Mary

6-1941405

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

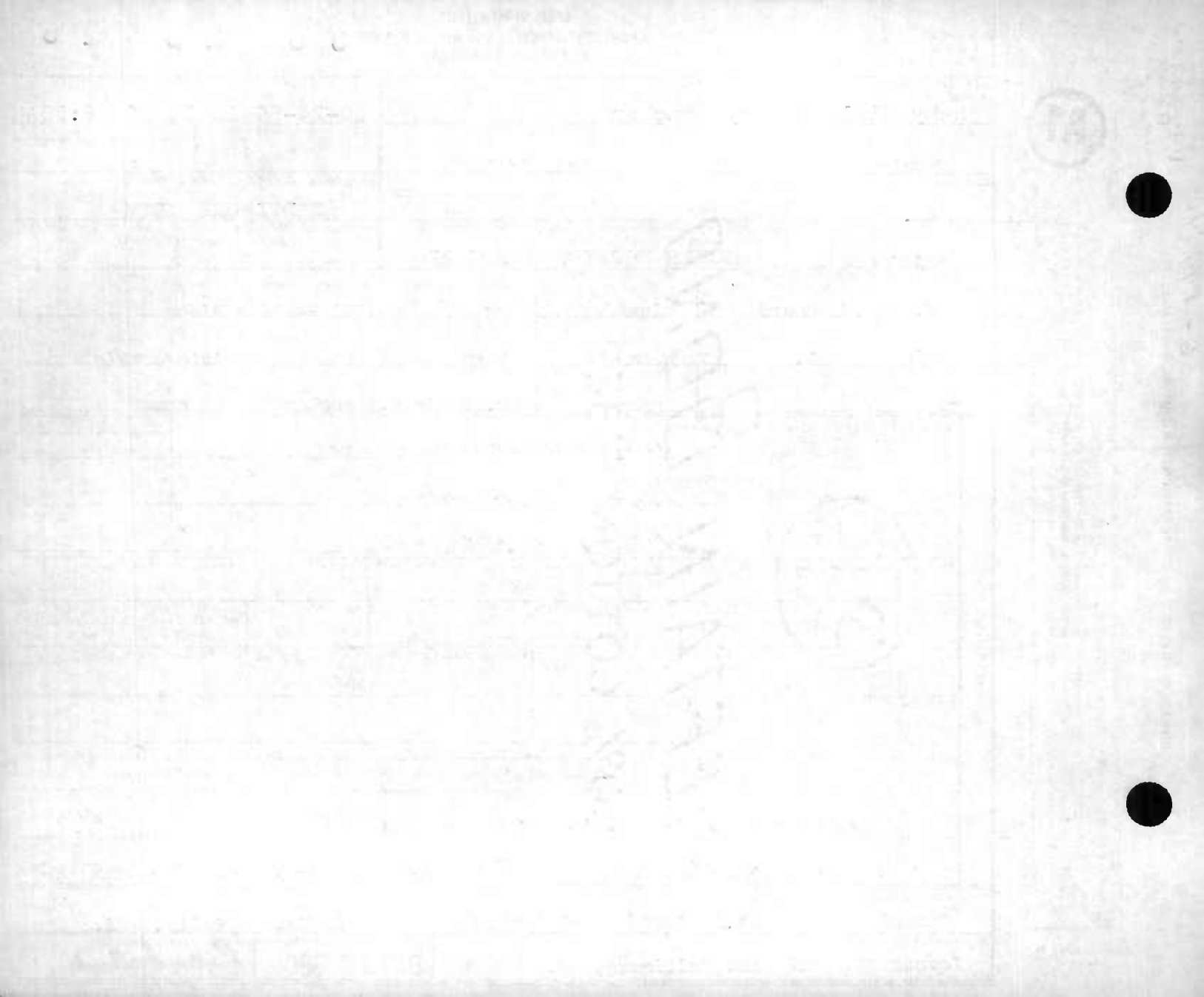
REG. NO. 80 25926

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH                                 |  |
| Baby Girl of Mary Vaughan  |  | Female   |  | White  |  | Oct. 24, 1980                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH             |  |
| Md.  |  | USA  |  |  |  | BALTIMORE CITY MD.                               |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |
| Baltimore  |  | JOHNS HOPKINS HOSPITAL   |  | none   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. STREET ADDRESS                              |  |
| Md.  |  | Howard   |  | Columbia   |  | 6921 Rawhide Ridge                               |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                         |  |
| Edwin T. Vaughan   |  | Mary Christoforakis  |  | no   |  | none   |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |
| Mr. Edwin T. Vaughan   |  | same   |  | same   |  | same   |  |
| 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)       |  | 21b. TIME OF INJURY                              |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | HOUR A.M. MONTH DAY YEAR                         |  |
|  |  |  |  |  |  | P.M. 19  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  | 21g. LOCATION                                    |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | STREET   |  | CITY OR TOWN COUNTY STATE                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/24 19 80, to 10/24 19 80, that (I) (we) lost saw the deceased alive on 10/24 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)            |  |
|  |  | Richard A. Molteni M.D.  |  | 10/24/80   |  | RICHARD A. MOLTENI                               |  |
| 22e. ADDRESS   |  | 22f. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  |
| JOHNS HOPKINS HOSP. BALTIMORE  |  |  |  | Burial   |  | Oct. 25, 1980                                    |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | 23e. NAME OF CEMETERY OR CREMATORY   |  | 23f. LOCATION                                    |  |
| Greek Orthodox   |  | Woodlawn   |  | Greek Orthodox   |  | Woodlawn Balto. Md.                              |  |
| 24. FUNERAL DIRECTOR   |  | 24a. DATE REC'D. BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE   |  | 24c. DATE REC'D. BY REGISTRAR                    |  |
| Leonard J. Ruck Inc. Baltimore, Md.  |  | OCT 27 1980  |  | R. J. Ruck   |  | OCT 27 1980                                      |  |

MEDICAL CERTIFICATION

99

1



131b: TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. To place and remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 2 7

REG. NO.

|   |  |   |   |  |                                   |  |  |
|---|--|---|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH   |   | MONTH DAY YEAR   |                                   | HOUR   |  |
| (SALLY) CECIL   |  | OCTOBER 25, 1980  |   | 10 25 80   |                                   | 8:45 AM  |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS  |  |
| FEMALE  | WHITE  | MONTH DAY YEAR<br>03 29 28  | 52 YRS.   | MONTHS DAYS  |                                   | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |  |  |
| VIRGINIA  | U.S.A.   |   | BALTIMORE CITY MD.  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| BALTIMORE   | THE JOHNS HOPKINS HOSPITAL   |   | HOUSEWIFE   |  | --                                |  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |                                   |  |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |                                   |  |  |
| MARYLAND  | ---  | BALTIMORE   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 432 RANDOM ROAD, 21229   |                                   |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |   |  |                                   |  |  |
| CECIL   | B. SANDERS   | MARY TUCKER   |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                   |  |  |
| NO  |  | 229-28-0131   |   | VALERIE JOHNSTON 432 RANDOM ROAD, 21229  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |   |   |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest   |  |   |   |  |                                   |  |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Small cell carcinoma of lung  |  |   |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |   |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |  |  |
|   |  | P.M. 19   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION CITY OR TOWN COUNTY STATE  |                                   |  |  |
|   |  |   |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/24, 19 80, to 10/25, 19 80, that (I) (we) last saw the deceased alive on 10/25, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |                                   |  |  |
| 22b. SIGNATURE  |  | DEGREE  |   | 22c. DATE SIGNED   |                                   |  |  |
| David Mishkin M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 10/25/80   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |   |  |                                   |  |  |
| David Mishkin M.D.  |  | Johns Hopkins Hosp 600 N. Wolfe St B9170  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| BURIAL  |  | 10-29-80  |   | NEW CATHEDRAL  |                                   | BALTIMORE CITY MARYLAND  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE                                     |  |
| HUBBARD FUNERAL HOME, INC.  |  | 4107 WILKENS AVE. 21229   |   | OCT 27 1980  |                                   | [Signature]  |  |

BP

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 2 8

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Henry John Voelker, Sr.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-20-80</b> |   |  | 2b. HOUR<br>M<br><b></b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>YEAR<br><b>10<sup>TH</sup>-30-07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3429 Dudley Ave.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. B.C.P.D.</b>                                   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b></b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Edward Voelker</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Ann Schubert</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-44-6123A</b>  |  | 17. INFORMANT ADDRESS<br><b>Mary J. Ceselsky, 1912 Edgewood Rd. 21234</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>5 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Lympho-proliferative disorder</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3300 N. Calvert St. Baltimore, Md.</b>  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Mar. 19 75</b> to <b>Oct 20 19 80</b> , that (I) (we) lost saw the deceased alive on <b>10/2 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Sheldon C. Kravitz M.D.</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/21/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sheldon C. Kravitz, M.D.</b>  |  | 22e. ADDRESS<br><b>3300 N. Calvert St.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10-24-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. Kelly</b>   |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 9 2 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Laura V. Voge</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 5 80</b> |   |  | 2b. HOUR<br><b>5:00 PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 19, 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>Maryland</b>  |  |   |   | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>Balt., Md. 21218</b><br><b>1503 Roundhill Road</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George H. Kerner</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary L. Holmes</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-03-5827</b>   |   | 17. INFORMANT <b>Husband:</b> ADDRESS <b>Balt., Md. 21218</b><br><b>Carl I. Voge 1503 Roundhill Rd.</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY<br><b>1749</b> IMMEDIATE CAUSE (a) <b>metastatic scirrhous carcinoma breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 3, 19 80</b> to <b>Oct 5, 19 80</b> that (I) (we) last saw the deceased alive on <b>10/4, 19 80</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>K.S. Silver MD</b>  |  |   |   | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>10/5/80</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kenneth H.C. Silver MD</b>   |  |   |   | 22e. ADDRESS<br><b>832 Evesham Ave Baltimore 2122</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Oct 7 1980</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Memorial</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis Maryland</b>                         |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 6 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 3 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |                        |  |   |  |                            |
|---|------------------------|--|---|--|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDWARD CARL VOGT, Jr.</b>   |                        |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 25 80</b> |  | 2b. HOUR<br><b>1:36p</b> M |
| 3 SEX<br><b>MALE</b>  | 4 RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 14 20</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>60</b> YRS  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |                            |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY,</b> MD   |                        | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL CENTER</b>   |                            |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self Emp</b>   |                        | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Service Station</b>  |   | 13a. STREET ADDRESS<br><b>627 BAYLOR ROAD 21061</b>  |                            |
| 13b. INSIDE CITY LIMITS?<br>YES NO <input checked="" type="checkbox"/>  |                        | 13c. CITY OR TOWN<br><b>Glen Burnie</b>  |   | 13d. STATE<br><b>MARYLAND</b>  |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>EDWARD C. VOGT Sr.</b>   |                        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CECIL SIMMONSON</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>YES</b><br>(IF YES, GIVE WAR OR DATES) <b>WWII</b>   |                            |
| 16b. SOCIAL SECURITY NO.<br><b>048122657</b>  |                        | 17. INFORMANT<br><b>Mrs. Frances G. Vogt (Wife)</b>  |   | 17. ADDRESS<br><b>Same as 13</b>   |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS</b><br><b>5621</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ABDOMINAL ABSCESS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>PERFORATED COLON (DIVERTICULITIS)</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last |                        |  |   |  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):<br><b>VASCULITIS, STEROID USE</b>  |                        |  |   |  |                            |
| 19a. DATE OF OPERATION  |                        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                        | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                            |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                        | 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                            |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                        | 22a. I certify that (1) this hospital attended the deceased from <b>OCTOBER 23</b> , 19 <b>80</b> , to <b>OCTOBER 25</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>OCTOBER 25</b> , 19 <b>80</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br><b>John H. Weigel, MD.</b> MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                            |
| 22c. DATE SIGNED<br><b>10-26-80</b>   |                        | 22d. ADDRESS<br><b>3900 LOCH RAVEN BLVD 21218</b>  |   | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |                            |
| 23b. DATE<br><b>Oct. 29, 80</b>   |                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Security Process</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Singleton Funeral Home, Glen Burnie, Md.</b>   |                        | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                            |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8025931

REG. NO.

|  |  |  |  |   |  |   |   |  |
|--|--|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MOLLIE WACHS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 30 80</b> |   | 2b. HOUR<br><b>305</b> M   |   |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>04 25 01</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>CITY</b> MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |  |  |   |  |   |   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ASROEL WOLOCK</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RIFKA</b>   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213 34 7147</b>   |  | 17. INFORMANT<br><b>MR. SANFORD WACHS</b><br><b>3640 LANGREHR RD. BALTO., MD 21207</b>  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>C.V.A.</b> |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/30/80</b> to <b>10/30/80</b> , that (I) (we) lost <b>10/30/80</b> above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Shmuel</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>10/30/80</b>   |   |  |
| 22d. PHYSICIAN'S NAME (THIS OFFICE)<br><b>Shmuel E. Gaiuso</b>   |  | 22e. ADDRESS<br><b>SINAI Hospital</b>  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>OCT/31, 1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE</b>   |  | 23d. LOCATION<br><b>BALTIMORE</b> COUNTY <b>MARYLAND</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia McBrady</b>   |   |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |  |  |  |                                      |  |   |  | REG. NO. 25932                               |  |
|--|---------|---|--|--|--|--------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE   |  | LAST                                 |  | 2a. DATE KNOWN OF DEATH   |  | 2b. HOUR                                     |  |
| Frank J. (WEGNER) Wagner   |         |   |  |  |  |                                      |  | 10 14 1980  |  | M  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.                       |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD                     |  |
| male   | white   | 9 19 20   |  | 60 YRS.  |  |                                      |  |   |  | 10 14 1980 12:07 PM                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |   |  |  |  |
| 35 MARYLAND  |         | U.S.A.  |  |  |  | Baltimore City                       |  |   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK)   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |   |  |  |  |
| Baltimore  |         | Baltimore City Hospital                                     |  | RETIRED  |  |                                      |  |   |  |  |  |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS                  |  |   |  |  |  |
| 35 MARYLAND  |         |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 809 S. DECKER AVE.                   |  |   |  |  |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  |  |  |                                      |  |   |  |  |  |
| 300 JOHN WAGNER  |         | MARY KWASNIAK   |  |  |  |                                      |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT  |  | ADDRESS                              |  |   |  |  |  |
| (YES, NO, OR UNKNOWN)  |         | 219 03 5778   |  | MRS. MARIE NOWAKOWSKI  |  | 809 S. DECKER                        |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u><br>4029<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |   |  |  |  |                                      |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |         |   |  |  |  |                                      |  |   |  |  |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |                                      |  | 20. AUTOPSY?  |  |  |  |
|  |         |   |  |  |  |                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED   |  |                                      |  |   |  |  |  |
|  |         | HOUR A.M. MONTH DAY YEAR                                    |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2   |  |                                      |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION  |  |                                      |  |   |  |  |  |
|  |         |   |  | STREET   |  | CITY OR TOWN                         |  | COUNTY  |  | STATE  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |  |  |                                      |  |   |  |  |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  | DATE SIGNED  |  |                                      |  |   |  |  |  |
| Hormez R. Guard, M.D.  |         | Assistant   |  | 10/15/ 80  |  |                                      |  |   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  |  |  |                                      |  |   |  |  |  |
| Hormez R. Guard, M.D.  |         | 111 Penn Street, Balto., MD 21201                           |  |  |  |                                      |  |   |  |  |  |
| 33a. BURIAL, CREMATION, REMOVAL  |         | 33b. DATE   |  | 33c. NAME OF CEMETERY OR CREMATORY   |  | 33d. LOCATION                        |  |   |  |  |  |
| BURIAL   |         | 10 18 1980  |  | SACRED HEART OF MARY   |  | BALTIMORE                            |  |   |  | MD.  |  |
| 34. FUNERAL DIRECTOR   |         | ADDRESS   |  | 35a. DATE REC'D. BY REGISTRAR  |  | 35b. REGISTRAR'S SIGNATURE           |  |   |  |  |  |
| RAYMOND L. KACZOROWSKI   |         | 2525 FLEET ST.  |  | OCT 21 1980  |  | L. J. Kaczorowski                    |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 3 3  
REG. NO.

|   |  |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JAY</b>   |  | FIRST<br><b>Arlington</b>  |  | MIDDLE<br><b>WAGNER, Sr.</b>   |  | LAST  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 12 1980</b>   |  | 2b. HOUR<br><b>10:05 AM</b>  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 02 06</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Iron Worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md. Drydock</b>   |  |   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1321 Patapsco Avenue</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George H. Wagner</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha McLosky</b>   |  |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>n/a</b>  |  | 17. INFORMANT<br><b>Ellen E. Wagner</b>  |  | ADDRESS<br><b>Same as #13</b>   |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Right Pleural Effusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Suspected MESOTHELIOMA</b>   |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>6 Months</b><br><b>6 Months</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/09</b> , 19 <b>80</b> , to <b>10/12</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/12</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Maureen L. Durkin</b>  |  |  |  | DEGREE<br><b>MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>10/12/80</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAUREEN L. DURKIN</b>   |  |  |  | 22e. ADDRESS<br><b>South Baltimore General Hospital</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/16/1980</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Ritchie Hwy., Baltimore, Md.</b>               |  |   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>McGully Funeral Home</b>  |  | BALTIMORE, MD., 21225<br><b>237 E. Patapsco Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |  |



THE ALBION WAGNER, JR. October 12 1930

Male Concession of 05 02 14

and others of the same name

Residing Palace

MAUREN L. DUREN  
MD  
10/12/30

1001 1100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8025934  |   | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>RICHARD HERALD WALLACE  |  |  | 2a. DATE OF DEATH<br>10 10 80                               |   |  | 2b. HOUR<br>2:40 PM   |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>Black   |   | 5. DATE OF BIRTH<br>8 12 09   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore General Hosp. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>REVEREND  |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTIMORE   |   | 13c. CITY OR TOWN<br>BALT.  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br>5100 BELLEVILLE AVENUE. |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHABLES WALLACE   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LUCY LEWIS |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>216-01-6226  |   | 17. INFORMANT<br>Mrs Evelyn Wallace   |  | ADDRESS 5100 Belleville Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>METASTATIC GASTRIC CA, partial</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>bowel obstruction</u>      |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>ABDOMEN<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) [this hospital] attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Gerard Lowder   |  |  |   | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED                               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GERARD LOWDER  |  |  |   | 22e. ADDRESS<br>SOUTH BALTIMORE GENERAL   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10-15-80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat'l Mem. Pk.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Chas. A. Rice FSPA  |  |  |   | ADDRESS<br>1300 Eutaw Place   |  | 25. DATE REC'D BY REGISTRAR<br>OCT 16 1980  |  | 26. DATE FILED BY REGISTRAR                    |  |

BP



10-1-10

10-1-10

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8025935 |  |
|---|--|---|--|---|--|---|--|--|--|---------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |  |  |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Vincent Anthony Walsh</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>10 26 80</b>   |  | 2b. HOUR<br><b>5<sup>10</sup> AM</b>   |  |         |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1-22-1909</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ind.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |         |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bless Martin</b>   |  |         |  |
| 13a. STATE<br><b>Ind.</b>   |  | 13b. COUNTY<br><b>Balt.</b>   |  | 13c. CITY OR TOWN<br><b>Balt.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>814 Hollins St. 21201</b>  |  |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Walsh</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Janekushas</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   |  |  |  |         |  |
| 16b. SOCIAL SECURITY NO.<br><b>219-16-7437</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Lillian J. Walsh - 814 Hollins St. 21201</b>   |  |   |  |   |  |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>5150</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DIFFUSE BIL. PNEUMONITIS, ? CHF ? FLUID OVERLOAD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CHRONIC INTERSTITIAL FIBROSIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 HOURS</b><br><b>8 DAYS / 2 DAYS</b><br><b>34 YEARS</b> |  |   |  |   |  |   |  |  |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>URINARY TRACT INFECTION, R/O CA OF UOIN R/O RENAL NEOPLASM</b>   |  |   |  |   |  |   |  |  |  |         |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>18 OCT 1980</b> to <b>26 OCT 1980</b> , that (I) (we) lost<br>saw the deceased alive on <b>26 OCT 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |         |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>10/26/80</b>  |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANASTASIO R. DE CASTRO</b>  |  |   |  | 22e. ADDRESS<br><b>St. Agnes Hospital</b>   |  |   |  |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10-29-1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Agnes Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balt. Ind.</b>                                 |  |  |  |         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John J. Corvan, Inc. 901 Hollins St.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 29 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |         |  |

17  
JULY 1911

ST. LOUIS HOSPITAL

ST. LOUIS

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "admission" and "discharge" are faintly visible.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 3 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |                                     |   |  |   |  |
|---|-------------------------------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JACOB J. WALTON  |                                     |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 26, 1980  |   | 2b. HOUR<br>04:15AM  |
| 3. SEX<br>Male  | 4. RACE<br>Negro                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 30 23  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VA   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL                     |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br>MD  |                                     | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2204 Henneman Avenue  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charlie Walton  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucy Booker  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |                                     | 16b. SOCIAL SECURITY NO.<br>229-18-3191   |  | 17. INFORMANT<br>ADDRESS<br>Frances L. Walton 2204 Henneman Ave.                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>INTRACTABLE HYPOTENSION</u><br><u>5712</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>MASSIVE VARICEAL HEMORRHAGE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ALCOHOLIC HEPATIC FAILURE / PORTAL HYPERTENSION</u> |                                     |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6h</u><br><u>6h</u><br><u>~3 mos.</u>                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                                     |   |  |   |  |
| 19a. DATE OF OPERATION  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/30/80</u> , 19____, to <u>10/26/80</u> , 19____, that (I) (we) lost<br>saw the deceased alive on <u>10/26/80</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |                                     |   |  |   |  |
| 22b. SIGNATURE<br><u>LD Snyder MD</u>   |                                     | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>10/26/80</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>LD SNYDER, MD (JHH H3127)</u>   |                                     | 22e. ADDRESS<br><u>THE JOHNS HOPKINS HOSP</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                                     | 23b. DATE<br>10/30/80   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |                                     |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 27 1980             |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

BP



*Handwritten signature*

OCT 1 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25937  
REG. NO.

|  |        |  |                          |   |                                |   |   |  |                      |   |  |
|--|--------|--|--------------------------|---|--------------------------------|---|---|--|----------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        | FIRST  | MIDDLE                   | LAST  | 2a. DATE OF DEATH              |   | MONTH   | DAY  | YEAR                 | 2b. HOUR  |  |
| (LOUENIA) VINE   |        |  |                          | WARD  | 10                             |   | 20  | 80   |                      | 8:10 AM   |  |
| 3 SEX  | 4 RACE |  | 5 DATE OF BIRTH          |   | 6 AGE (IN YEARS LAST BIRTHDAY) |   | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS      |   |  |
| Female   | Black  |  | 04 31 91                 |   | 99 YRS                         |   | MONTHS DAYS   |  | HOURS MIN            |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |        | 7b CITIZEN OF WHAT COUNTRY?  |                          | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |   |  |                      |   |  |
| MD   |        | USA  |                          |   |                                | Baltimore City MD   |   |  |                      |   |  |
| 10 CITY OR TOWN OF DEATH   |        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                          |   |                                | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)        |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                      |   |  |
| Baltimore  |        | Greater Penn N/H   |                          |   |                                |   |   |  |                      |   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |        |  | 13b. COUNTY              |   | 13c. CITY OR TOWN              |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |   |  |
| MD   |        |  |                          |   | Baltimore                      |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3824 Fairview Avenue |   |  |
| 14 FATHER'S NAME   |        |  | 15. MOTHER'S MAIDEN NAME |   |                                |   |   |  |                      |   |  |
| FIRST MIDDLE LAST  |        |  | FIRST MIDDLE LAST        |   |                                |   |   |  |                      |   |  |
| John Robinson  |        |  | Mary                     |   |                                |   |   |  |                      |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |        | 16b SOCIAL SECURITY NO.  |                          | 17 INFORMANT  |                                | ADDRESS   |   |  |                      |   |  |
| No   |        | 213-05-0001  |                          | George Price  |                                | 3824 Fairview Avenue  |   |  |                      |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Chronic Renal Failure</u><br>585-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |        |  |                          |   |                                |   |   |  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |        |  |                          |   |                                |   |   |  |                      |   |  |
| 19a DATE OF OPERATION  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          |   |                                | 20a AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                      |   |  |
| N/A  |        |  |                          |   |                                | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                      |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |        | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                          | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                |   |   |  |                      |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |        | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                  |                          | 21f LOCATION<br>STREET  |                                | CITY OR TOWN  |   | COUNTY   |                      | STATE   |  |
|  |        |  |                          |   |                                |   |   |  |                      |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>11 AUG</u> 19 <u>80</u> to <u>20 October 80</u> , that (I) (we) last saw the deceased alive on <u>06 Oct</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.            |        |  |                          |   |                                |   |   |  |                      |   |  |
| 22b SIGNATURE  |        | DEGREE   |                          |   |                                | 22c DATE SIGNED   |   |  |                      |   |  |
| Richard Tyson, M.D.  |        |  |                          |   |                                | 10-20-80  |   |  |                      |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |        | 22e ADDRESS  |                          | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |                                |   |   |  |                      |   |  |
| Richard Tyson, M.D.  |        | 936 W. NORTH AVE.<br>BALTIMORE MD 21217  |                          |   |                                |   |   |  |                      |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)   |        | 23b DATE   |                          | 23c NAME OF CEMETERY OR CREMATORY   |                                | 23d LOCATION<br>CITY OR TOWN  |   | COUNTY   |                      | STATE   |  |
| Burial   |        | 10/24/80   |                          | Mt. Calvary Cem.  |                                | Baltimore   |   | Co.  |                      | MD  |  |
| 24 FUNERAL DIRECTOR<br>NAME  |        | ADDRESS  |                          | 25a DATE REC'D. BY REGISTRAR  |                                | 25b REGISTRAR'S SIGNATURE   |   |  |                      |   |  |
| Wm. C. March F/H   |        | 1101 E. North Ave.   |                          | OCT 22 1980   |                                | Richard Tyson   |   |  |                      |   |  |

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 5 9 3 8<br>REG. NO.  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>MATTHEW BOY SCOTT WARD</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>OCTOBER 20, 1980</b>   |  | 2b. HOUR <b>01:22 PM</b>  |  |
| 3 SEX <b>Male</b>   |  | 4 RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 18, 1980</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>2</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Hancock</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <b>4 Fulton Street</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Jeffrey L. Ward</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Robin L. Shoemaker</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>None</b>   |  | 17. INFORMANT ADDRESS <b>Jeffrey L. Ward 4 Fulton St. Hancock Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>7469<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Presumed congenital cardiac disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/20/80</b> , 19 <b>80</b> , to <b>10/20</b> , 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10/20</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Richard A. Molteni</b> DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>10/20/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD A. MOLTENI</b>   |  |  |  | 22e. ADDRESS <b>CMSC 501 JHH Baltimore</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>10-22-80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Tonoloway Baptist</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fulton Penna.</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>Richard J. Shove</b> ADDRESS <b>Hancock Md</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>OCT 27 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>  |  |

194 0750  
WARD.

1880

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

1880

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25939

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST (THOMAS MIDDLE ALOYSIUS WARGA)<br><i>Thomas S ALOYSIUS Warga</i>                               |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10-16-80</i>  |  | 2b. HOUR<br><i>359 PM</i>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>FEBRUARY 11, 1912</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b><br>YRS MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE, MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE, MD.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE CITY HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO. CITY COURTHOUSE</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>-----</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH WARGA</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE KRYSTINIAK</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES W.W.II</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>212-07-4506</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>3454 McSHANE WAY.<br/>DUNDALK, 21222, MD.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>D S Siegel MD</i>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br><i>10/16/80</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Siegel</i>  |  | 22e. ADDRESS<br><i>Balt City Hosp</i>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-20-80.</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>4430 BELAIR RD. BALTO., MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles A. Seiler &amp; Son, Inc.</i>  |  | 25a. ADDRESS<br><b>901 S. CONKLING ST.<br/>BALTO., 21224, MD.</b>   |  | 25b. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1980</b>   |  | 25c. REGISTRAR'S SIGNATURE<br><i>Robert McCreedy</i>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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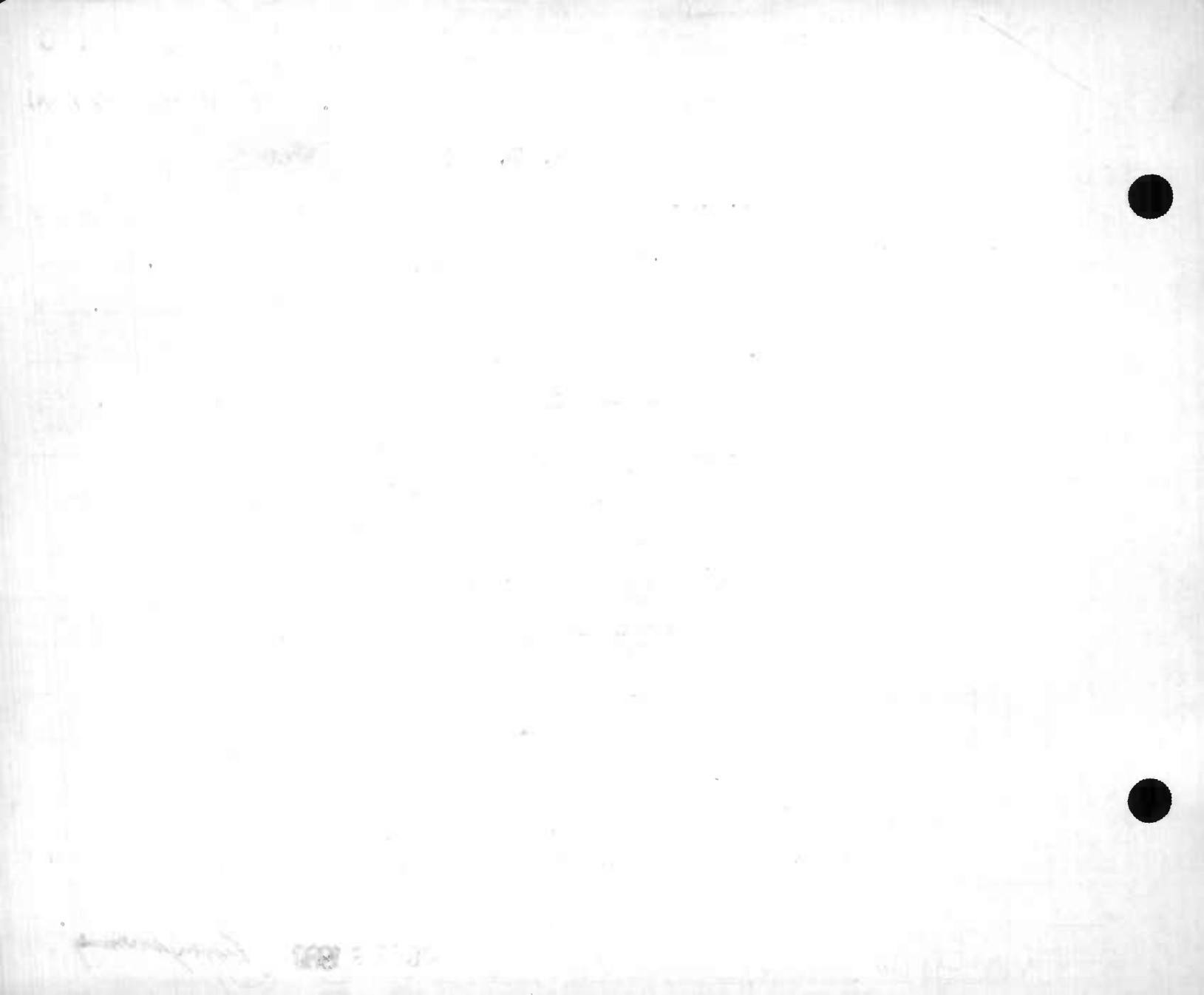
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| FOR<br>STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 0 2 5 9 4 0<br>REG. NO.  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ANNA M. WARREN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCT. 10-11-80                         |  | 2b. HOUR<br>8 P.M.  |
| 3. SEX<br>Female  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>APR. 7, 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.                           |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Federal Hill N.H., 1213 Light St. Baltimore |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>DOMESTIC |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTIMORE  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM A. JENKINS  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>AMELIA EPPS  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-09-4471   |  | 17. INFORMANT<br>ADDRESS<br>BEATRICE REID/931 RUTLAND AVE. #05                       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 410- Cardiac arrest due to M.I.<br>DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular disease yrs.<br>DUE TO, OR AS A CONSEQUENCE OF (c) S.P. (D) A.K. amputation<br>Approximate interval between onset and death<br>Terminal<br>6 months |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Peripheral Vascular disease   |  |   |  |  |   |
| 19a. DATE OF OPERATION<br>8.4.1980  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gangrene (L) foot   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |
| 22b. SIGNATURE<br>Amatun Noor Naeem MD  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>10/12/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>AMATUN NOOR NAEEM  |  | 22e. ADDRESS<br>501 DOLPHIN ST. BALTO MD 21217  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>10/16/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WESTVIEW MEM PARK                              |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE BALTO MD.   |  | 23e. DATE REC'D. BY REGISTRAR<br>OCT 16 1980  |  | 23f. REGISTRAR'S SIGNATURE   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>MARSHALL W JONES Jr.  |  | ADDRESS<br>Edmonds Ave  |  | BALTO MD.  |   |

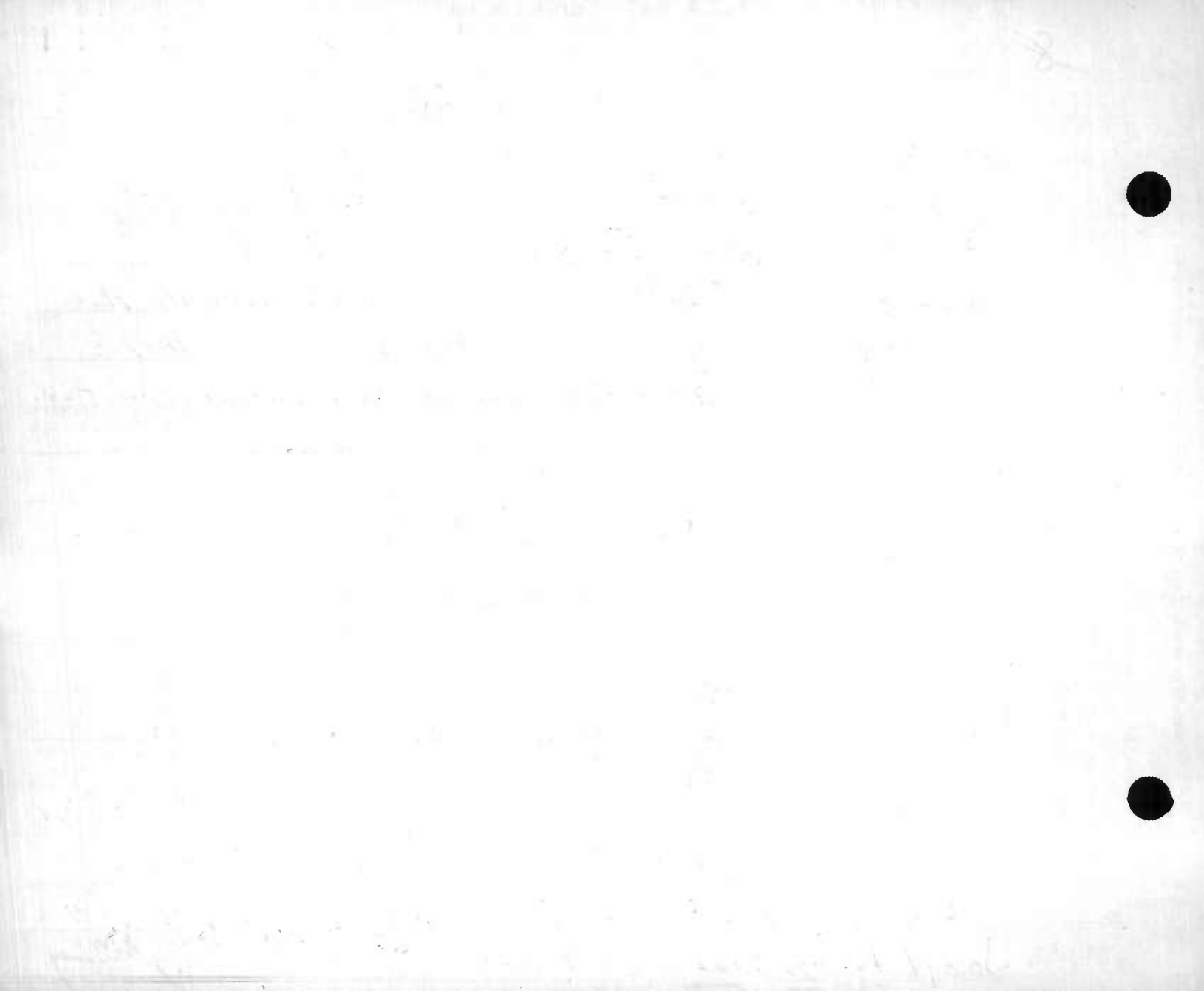


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | 8025941   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>OTIS   |  | MIDDLE  |  | LAST<br>WARREN SR.   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10-26-80  |  | 2b. HOUR<br>6 1/2 AM  |  |
| 3. SEX<br>male  |  | 4. RACE<br>Col  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-11-1899  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7b. IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bacon Secours Hosp |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>BALTO.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2416 Arundel Ave.   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jerry Warren  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Hester Harris  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213-34-7169  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Rose O Warren 2416 Arundel Ave.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Decompensated Chronic Cor Pulmonale</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic Obstructive Pulmonary Disease</u><br>Approximate Interval Between Onset and Death: <u>years</u> |  |   |  |   |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>80 10/26/80  |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>10-18</u> <u>80</u> to <u>10/26</u> <u>80</u> , that (I) (we) last saw the deceased alive on <u>10-26</u> <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br>u [Signature]   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>10/27/80   |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARCELO P. ROBERTS   |  | 22e. ADDRESS<br>1940 W. Calhoun St Balto md 21223   |  |   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10-31-80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Memorial  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. Co. Md  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ  |  | ADDRESS<br>2222 W. North Ave.   |  | 25. DATE REC'D. BY REGISTRAR<br>NOV 7 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | REG. NO.  |  |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)<br>Harold E. Warrener   |  |  |  |   |  | 2a. DATE OF DEATH<br>October 28, 1980  |  | 2b. HOUR<br>A M                                       |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH<br>May 10, 1902  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>78  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4405 Hickory Avenue |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Carpenter |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>4405 Hickory Avenue            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214 12 9490   |  | 17 INFORMANT<br>Edna M. Colley   |  |   |  | ADDRESS<br>Same  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4029 HYPERTENSIVE CARDIOVASCULAR DLS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>YEARS |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Nathan Rosenblum  |  |  |  | DEGREE<br>MD   |  |   |  | 22c. DATE SIGNED<br>29 Oct 1980  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Nathan Rosenblum   |  |  |  | 22e. ADDRESS<br>7600 Osler Drive Towson, Md.   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>31 Oct. 80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Jessops Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville, Balto. Co. Md.    |  |  |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Burgee Funeral Home  |  |  |  | ADDRESS<br>3631 Falls Rd. 21211  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 29 1980                                  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |

October 25, 1960

Mr. J. Edgar Hoover

Washington, D.C.

Dear Mr. Hoover:

I am writing to you regarding the matter of the

construction of the new building for the

Department of Justice.

I have been informed that the construction

of the building is well advanced and that

it will be completed by the end of the year.

I am sure that the new building will be a

great asset to the Department and that it

will provide a more suitable environment for

the work of the Department.

I am sure that you will be pleased to hear

that the construction is progressing so well.

I am, Sir, very respectfully,

Yours truly,

John Edgar Hoover

John Edgar Hoover

Director, Federal Bureau of Investigation

Washington, D.C.

October 25, 1960

Enclosed for you are two copies of the

report of the Committee on the Construction

of the new building for the Department of

Justice.

I am sure that you will find the report

of interest and that it will provide you

with the information you need.

I am, Sir, very respectfully,

Yours truly,

John Edgar Hoover

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |   |  |                                |  |  |  |              |  |                    |  |
|--|--|--|--|---|--|---|--|---|--|--------------------------------|--|--|--|--------------|--|--------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Vincent   |  | MIDDLE<br>Ward  |  | LAST<br>Waskevich   |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED   |  | MONTH<br>10                    |  | DAY<br>14  |  | YEAR<br>1980 |  | 2b. HOUR<br>M<br>1 |  |
| 3. SEX<br>male   |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 20, 1943  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>37 YRS.   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 2c. DATE<br>PRONOUNCED<br>DEAD |  | MONTH<br>10  |  | DAY<br>14    |  | YEAR<br>1980       |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |   |  |                                |  |  |  |              |  |                    |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital (MIEM) |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>Sales Supervisor      |  |                                |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>Distributing Co.   |  |              |  |                    |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Reisterstown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>206 Chartley Drive   |  |                                |  |  |  |              |  |                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Vincent Edward Waskevich   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Frances Barstow                           |  |   |  |                                |  |  |  |              |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes   |  |  |  | (IF YES, GIVE WAR OR DATES)<br>Viet Nam   |  | 16b. SOCIAL SECURITY NO.<br>213-40-0125   |  | 17. INFORMANT<br>ADDRESS<br>206 Chartley Dr.<br>Patricia Ann Waskevich Reisterstown, Md.  |  |                                |  |  |  |              |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>multiple injuries</u><br>8147<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |  |  |   |  |   |  |   |  |                                |  |  |  |              |  |                    |  |
| 19a. DATE OF OPERATION   |  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |                                |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |              |  |                    |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>11:08 AM 10/14/80                            |  |   |  |                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Pedestrian struck by truck backing up |  |              |  |                    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK   |  |  |  |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>parking lot                   |  |   |  |                                |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Maggie's Restaurant, Westminster, Carroll Co, MD                  |  |              |  |                    |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .                             |  |  |  |   |  |   |  |   |  |                                |  |  |  |              |  |                    |  |
| ACTUAL<br>SIGNATURE <u>Hormez R. Guard</u>   |  |  |  |   |  | TITLE (SPECIFY)<br>Assistant  |  |   |  |                                |  | DATE<br>SIGNED 10/15/80  |  |              |  |                    |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Hormez R. Guard, M.D.   |  |  |  |   |  | ADDRESS 111 Penn St. Balto., MD. 21201  |  |   |  |                                |  |  |  |              |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial  |  |  |  | 23b. DATE<br>Oct. 17, 1980  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Evergreen Memorial Gardens, Finksburg, Carroll, Md. |  |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Finksburg, Carroll, Md.  |  |              |  |                    |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>H. E. Ehrhardt</u> ADDRESS Owings Mills, Md.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 16 1980  |  |   |  |                                |  | 25b. REGISTRAR'S SIGNATURE<br><u>H. E. Ehrhardt</u>  |  |              |  |                    |  |

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Washington, D.C. 20535

October 10, 1980

U.S.A.

Director, Federal Bureau of Investigation

Re: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

cc: [Illegible]

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[Illegible]

[Illegible]

[Illegible]

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[Illegible]

[Illegible]

[Illegible]

[Illegible]

Oct 14 1980

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate to be completed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 4 4  
REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | OCTOBER 03, 1980  |  | 11:28 AM  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male   |  | Black  |  | MONTH DAY YEAR<br>1 4 27  |  | 53 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Md.  |  | USA  |  |   |  | BALTIMORE CITY MD   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Balto.   |  | THE JOHNS HOPKINS HOSPITAL   |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. STATE   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.  |  |  |  | Balto.  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS   |  |   |  |
| FIRST MIDDLE LAST<br>Clarence Dennis   |  | FIRST MIDDLE LAST<br>Beatrice Washington   |  | 1429 E. Eager Street  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |
| Yes  |  |  |  | Lucille Edwards   |  | 1429 E. Eager St.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (a) <u>end stage liver disease</u>   |  | 4 wks  |  |   |  |   |  |
| 5713   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | 10 yrs   |  |   |  |   |  |
| (b) <u>chronic alcohol abuse</u>   |  |  |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | 1 wk   |  |   |  |   |  |
| (c) <u>gastrointestinal hemorrhage</u>   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>80</u> , to <u>10/3</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/3</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>DALE RENDLUND</u>   |  | 22c. DATE SIGNED<br>10/3/80   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR   |  | 22g. REGISTRAR'S SIGNATURE  |  |
| DALE RENDLUND  |  | 601 N. Broadway, Baltimore, Maryland   |  | OCT 6 1980  |  | <u>Anthony McCreedy</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial   |  | 10/9/80  |  | King Mem. Park  |  | Baltimore Co., Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 24b. ADDRESS   |  | 24c. DATE REC'D. BY REGISTRAR   |  | 24d. REGISTRAR'S SIGNATURE  |  |
| Wm C March F/H   |  | 1101 E. North Ave.   |  | OCT 6 1980  |  | <u>Anthony McCreedy</u>   |  |

MEDICAL CERTIFICATION

MR. D. I. P. I. O. S. O.  
FORN. - NO. 1011258  
15. 10. 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                    |  |
|---|--|--|--|--|--|---|--|------------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 8025945  |  | REG. NO.   |  |   |  |                                    |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |                                    |  |
| Susie P. Washington   |  |  |  | 10 14 1980   |  | 9P  |  | M                                  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS |  |
| female  |  | BLACK  |  | 6 15 07  |  | 73 YRS.   |  | MONTHS DAYS HOURS MIN              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                    |  |
| VA.   |  | USA  |  |  |  | Baltimore MD.   |  |                                    |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                    |  |
| Baltimore   |  | Greater Penn. N/H  |  |  |  |   |  |                                    |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS                |  |
| MARYLAND  |  |  |  | Baltimore  |  |   |  | Greater Penn. N.H.                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |                                    |  |
| Annias Claiborne  |  | Elnora Torraine  |  |  |  |   |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT ADDRESS  |  |   |  |                                    |  |
| No  |  | 220-12-8515  |  | Thomas Claiborne 1806 Saratoga   |  |   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  |  | Congestive Heart Failure   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                    |  |
| 4140  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease  |  | years   |  |                                    |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | (c)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | years   |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | Cerebrovascular Accident   |  |  |  |   |  |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                    |  |
| N/A   |  |  |  |  |  |   |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                    |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |                                    |  |
| 22a. I certify that (this hospital) attended the deceased from 08-03-1979 to 10-14-1980, that (I/we) last saw the deceased alive on 10-08-1980 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. |  | 22b. SIGNATURE DEGREE  |  | 22c. DATE SIGNED   |  |   |  |                                    |  |
| Richard Tyson M.D.  |  |  |  | 10-15-80   |  |   |  |                                    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                                    |  |
| Richard Tyson, M.D.   |  | 936 W. NORTH AV., BALTO MD 21217   |  |  |  |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |                                    |  |
| Burial  |  | 10/18/80   |  | King Cemetery  |  | Baltimore MD.   |  |                                    |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                    |  |
| Wm. C. March Funeral Home 1101 E. North Ave.  |  | OCT 17 1980  |  | Richard McCreedy   |  |   |  |                                    |  |



607 Penna Ave

PO 21

Greater Penn. W.H.

g. m. l. c.

g. m. l. c.

g. m. l. c.

Philadelphia, Pa.

Philadelphia, Pa.

Philadelphia, Pa.

Philadelphia, Pa.

Philadelphia, Pa.

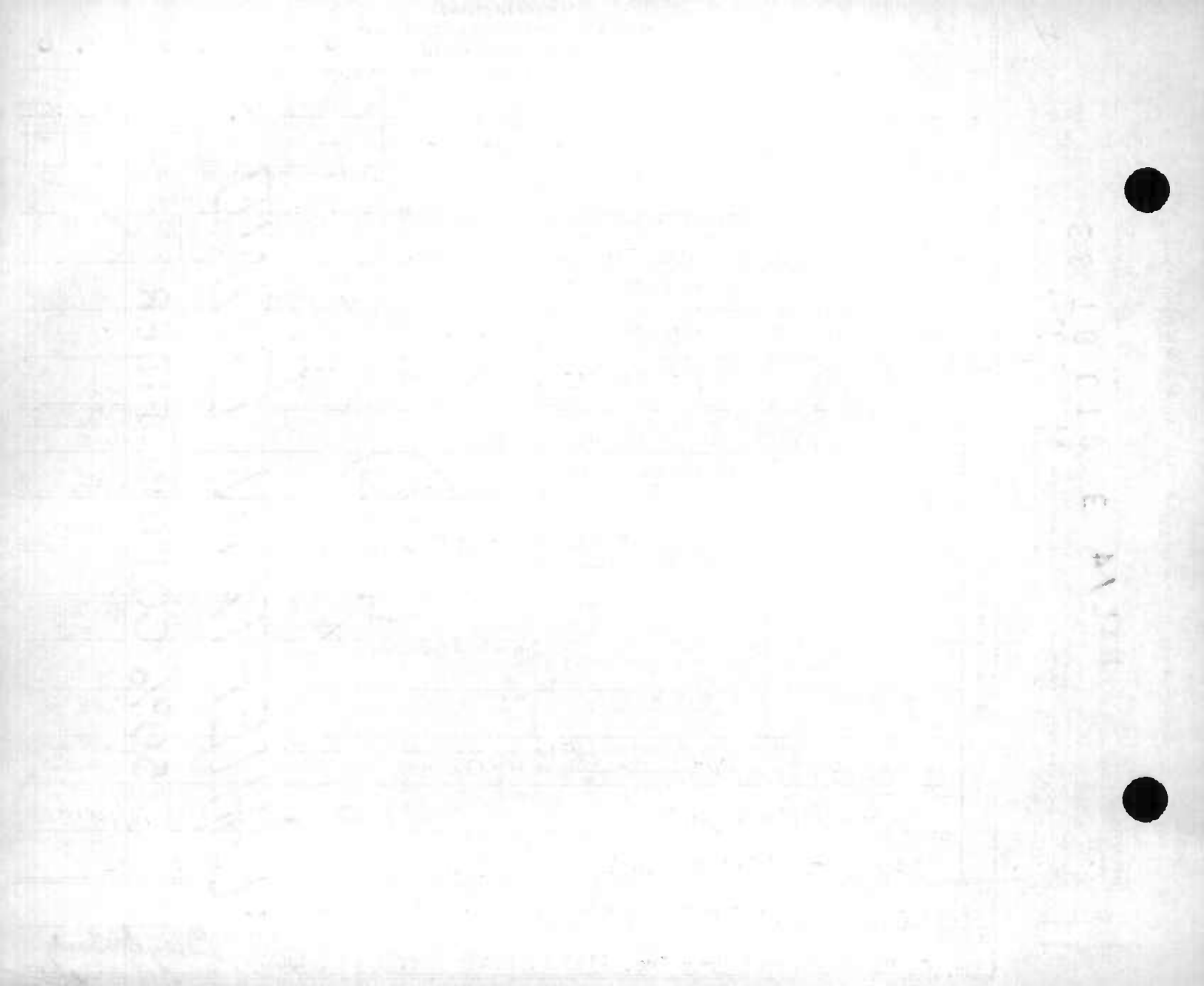
Philadelphia, Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and deliver them to the funeral home within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   | 8 0 2 5 9 4 6<br>REG. NO.  |   |
|--|--|--|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>DORA B WATERS  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>OCTOBER 14 1980  |   | 2b. HOUR<br>04:20 PM   |   |
| 3. SEX<br>Female   | 4. RACE<br>Black   | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 22 10   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                            |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br>MD   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>240 N. Dallas Court   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Archie Loyitt   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Winnie Norris  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>214-14-9512  |   | 17. INFORMANT ADDRESS<br>Herbert Waters 926 N. Chester St.                           |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>1991<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTESTINAL OBSTRUCTION</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADENOCARCINOMA</u> |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MINUTES<br>10 DAYS<br>7 YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> , 19 <u>80</u> , to <u>10/14</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.                                |  |  |   |  |   |
| 22b. SIGNATURE<br>David B. Pearse M.D.   |  |  |   | 22c. DATE SIGNED<br>10/14/80   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID B. PEARSE M.D.  |  |  |   | 22e. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>10/19/80  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park                             |   |
| 23d. LOCATION CITY OR TOWN<br>Baltimore  |  | COUNTY<br>MD   |   | STATE  |   |
| 24. FUNERAL DIRECTOR NAME<br>Wm. C. March Funeral Home Inc. 1101 E. North Ave.   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>OCT 15 1980   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| <div> <div>1. FOR STATE REGISTRAR</div> <div> <div>1. DECEASED NAME (TYPE OR PRINT)</div> <div>FIRST</div> <div>MIDDLE</div> <div>LAST</div> </div> </div> <div> <div>2. DATE OF DEATH</div> <div>MONTH</div> <div>DAY</div> <div>YEAR</div> </div> <div> <div>2b. HOUR</div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>3. SEX</div> <div>FEMALE</div> </div> <div> <div>4. RACE</div> <div>WHITE</div> </div> <div> <div>5. DATE OF BIRTH</div> <div>MONTH</div> <div>DAY</div> <div>YEAR</div> </div> <div> <div>6. AGE (IN YEARS LAST BIRTHDAY)</div> <div>YRS.</div> </div> <div> <div>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</div> <div>MARYLAND</div> </div> <div> <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div> </div> <div> <div>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div> <div> <div>9. BALTIMORE CITY OR COUNTY OF DEATH</div> <div>BALTIMORE CITY</div> </div> |  |  |  |  |  |  |  |  |  |
| <div> <div>10. CITY OR TOWN OF DEATH</div> <div>BALTIMORE</div> </div> <div> <div>11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</div> <div>3900 N. CHARLES ST.</div> </div> <div> <div>12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)</div> </div> <div> <div>12b. KIND OF BUSINESS OR INDUSTRY</div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>13a. STATE</div> <div>MD.</div> </div> <div> <div>13b. COUNTY</div> <div>BALTIMORE</div> </div> <div> <div>13d. INSIDE CITY LIMITS?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div> <div> <div>13e. STREET ADDRESS</div> <div>3900 N. CHARLES ST. 21218</div> </div>  |  |  |  |  |  |  |  |  |  |
| <div> <div>14. FATHER'S NAME</div> <div>FIRST</div> <div>MIDDLE</div> <div>LAST</div> </div> <div> <div>15. MOTHER'S MAIDEN NAME</div> <div>FIRST</div> <div>MIDDLE</div> <div>LAST</div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)</div> <div>NO</div> </div> <div> <div>16b. SOCIAL SECURITY NO.</div> <div>220-44-5104</div> </div> <div> <div>17. INFORMANT</div> <div>ADDRESS</div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <i>Mile stone carcinoma colon</i></div> <div>1539</div> <div>DOE TO, OR AS A CONSEQUENCE OF</div> <div>(b) _____</div> <div>DOE TO, OR AS A CONSEQUENCE OF</div> <div>(c) _____</div> <div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div><i>5 yrs</i></div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div><i>Blud loss anemia</i></div> </div>  |  |  |  |  |  |  |  |  |  |
| <div> <div>19a. DATE OF OPERATION</div> </div> <div> <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> </div> <div> <div>20a. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div> </div> <div> <div>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div> </div> <div> <div>21b. TIME OF INJURY</div> <div>HOUR</div> <div>A.M.</div> <div>MONTH</div> <div>DAY</div> <div>YEAR</div> </div> <div> <div>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)</div> </div>  |  |  |  |  |  |  |  |  |  |
| <div> <div>21d. INJURY OCCURRED</div> <div>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK</div> </div> <div> <div>21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</div> </div> <div> <div>21f. LOCATION</div> <div>STREET</div> <div>CITY OR TOWN</div> <div>COUNTY</div> <div>STATE</div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>22a. I certify that (I) (this hospital) attended the deceased from <i>1974</i> 19____, to <i>death</i> 19____, that (I) (we) last saw the deceased alive on <i>10/1/84</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</div> </div>  |  |  |  |  |  |  |  |  |  |
| <div> <div>22b. SIGNATURE</div> <div>DEGREE</div> <div>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/></div> <div>22c. DATE SIGNED</div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>22d. PHYSICIAN'S NAME (TYPE OR PRINT)</div> <div>ERNEST C. BROWN MD.</div> </div> <div> <div>22e. ADDRESS</div> <div>1134 YORK RD. 21093</div> </div>   |  |  |  |  |  |  |  |  |  |
| <div> <div>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</div> <div>CREMATION</div> </div> <div> <div>23b. DATE</div> <div>NOV. 3, 1980</div> </div> <div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>GREEN MOUNT CREMATORY</div> </div> <div> <div>23d. LOCATION</div> <div>CITY OR TOWN</div> <div>COUNTY</div> <div>STATE</div> </div>  |  |  |  |  |  |  |  |  |  |
| <div> <div>24. FUNERAL DIRECTOR</div> <div>NAME</div> <div>ADDRESS</div> </div> <div> <div>25a. DATE REC'D. BY REGISTRAR</div> <div>25b. REGISTRAR'S SIGNATURE</div> </div>  |  |  |  |  |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |  |   |  |   |   |  |   |  |  |  |  |   |  |                                     |  |
|---|--|---|--|---|---|--|---|--|--|--|--|---|--|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JANIE JORDAN WATKINS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 20 80</b>                       |   | 2b. HOUR<br><b>8:40 P.M.</b>                                  |  |   |  |  |  |  |   |  |                                     |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 18 01</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |  |   |  |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Alabama</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |  |  |  |  |   |  |                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>High's Dairies</b>   |  |  |  |   |  |                                     |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1617 St. Paul Street</b> |  |  |   |  |                                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN STRINGER JORDAN</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CORA JOSEPHINE GREEN</b> |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>    |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-26-9534</b> |  | 17. INFORMANT<br>ADDRESS<br><b>Balto. Md. 21228</b><br><b>M. S. Ronald Watkins 6307 Chesworth Rd.</b> |  |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute myocardial Infarction, complete heart failure</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Hypertension, Pericarditis, acute renal failure, cerebral hypoxia</b> |  |   |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |                                     |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |   |  |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |   |  |  |  |  |   |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |  |   |  |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/19</b> , 19 <b>80</b> , to <b>10/20</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/20/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |  | 22b. SIGNATURE<br><b>A.R. Navarro, MD</b>      |  | DEGREE  |  | 22c. DATE SIGNED<br><b>10/20/80</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A.R. Navarro, MD</b>  |  |   |  |   | 22e. ADDRESS<br><b>St. Agnes Hospital 900 S. Caton Avenue</b> |  |   |  |  |  |  |   |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>10-24-80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b>       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Maryland</b>                  |  |  |  |  |   |  |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>   |  |   |  |   | BALTO. MD. 21229  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 23 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Kelly</b>   |  |  |   |  |                                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-335-3000.

UNITED STATES

DEPARTMENT OF JUSTICE

WASHINGTON

TO :

THE ATTORNEY GENERAL

FROM :

THE ATTORNEY GENERAL

THE ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |   | 8025949                                      |  |
|--|--|--|--|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO.   |  |  |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST  |  |  | 2. DATE OF DEATH   |  |  | MONTH DAY YEAR  |  |  |
| JAMES  |  |  | WATSON   |  |  | 10   |  |  | 20 80   |  |  |
| 3 SEX  |  |  | 4 RACE   |  |  | 5 DATE OF BIRTH  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  |  |
| MALE   |  |  | BLACK  |  |  | 06 28 10   |  |  | 70 YRS.   |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| MD   |  |  | USA  |  |  |  |  |  | BALTO CITY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| BALTO MD   |  |  | UNIV MD HOSP   |  |  | Laborer  |  |  | Bendix Corp.  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b. CITY OR TOWN  |  |  | 13c. INSIDE CITY LIMITS?   |  |  | 13d. STREET ADDRESS   |  |  |
| MD   |  |  | BALTO CITY   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 12/3 LIGHT ST   |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |   |  |  |
| WILL   |  |  | Watson   |  |  | Mae  |  |  | (Watson)  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | ADDRESS   |  |  |
| NO   |  |  | 217-88-9489  |  |  | Mary Mack  |  |  | 201 N Broadway St #20B  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) SEPTIC SHOCK   |  |  |  |  |  |  |  |  |   | 1 DAY  |  |
| 5119   |  |  |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |   |  |  |
| (b) PNEUMONIA  |  |  |  |  |  |  |  |  |   | 2 DAYS                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |   |  |  |
| (c) MALIGNANT RIGHT PLEURAL EFFUSION   |  |  |  |  |  |  |  |  |   | UNK  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |  |  |  |  |  |  |  |   |  |  |
| RIGHT PNEUMOTHORAX   |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |
|  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |   |  |  |
|  |  |  | P.M. 19  |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY   |  |  | 21f. LOCATION  |  |  |   |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | STREET   |  |  | CITY OR TOWN COUNTY STATE   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10/17 19 80 to 10/20 19 80, that (I) (we) last saw the deceased alive on 10/20 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |   |  |  |
| 22a. SIGNATURE   |  |  |  |  |  | DEGREE   |  |  | 22c. DATE SIGNED  |  |  |
| Peter Condros MD   |  |  |  |  |  |  |  |  | 10/20/80  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  |  | 22e. ADDRESS   |  |  |   |  |  |
| PETER CONDRO JR MD   |  |  |  |  |  | 22 SOUTH GREENE ST BALTO MD  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION   |  |  |
| BURIAL   |  |  | 10/25/80   |  |  | Md. Nat'l Park   |  |  | BALREL MD.  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| LeRoy Harris F/S 4520 PenLucy Rd.  |  |  |  |  |  | OCT 23 1980  |  |  | [Signature]   |  |  |

BP



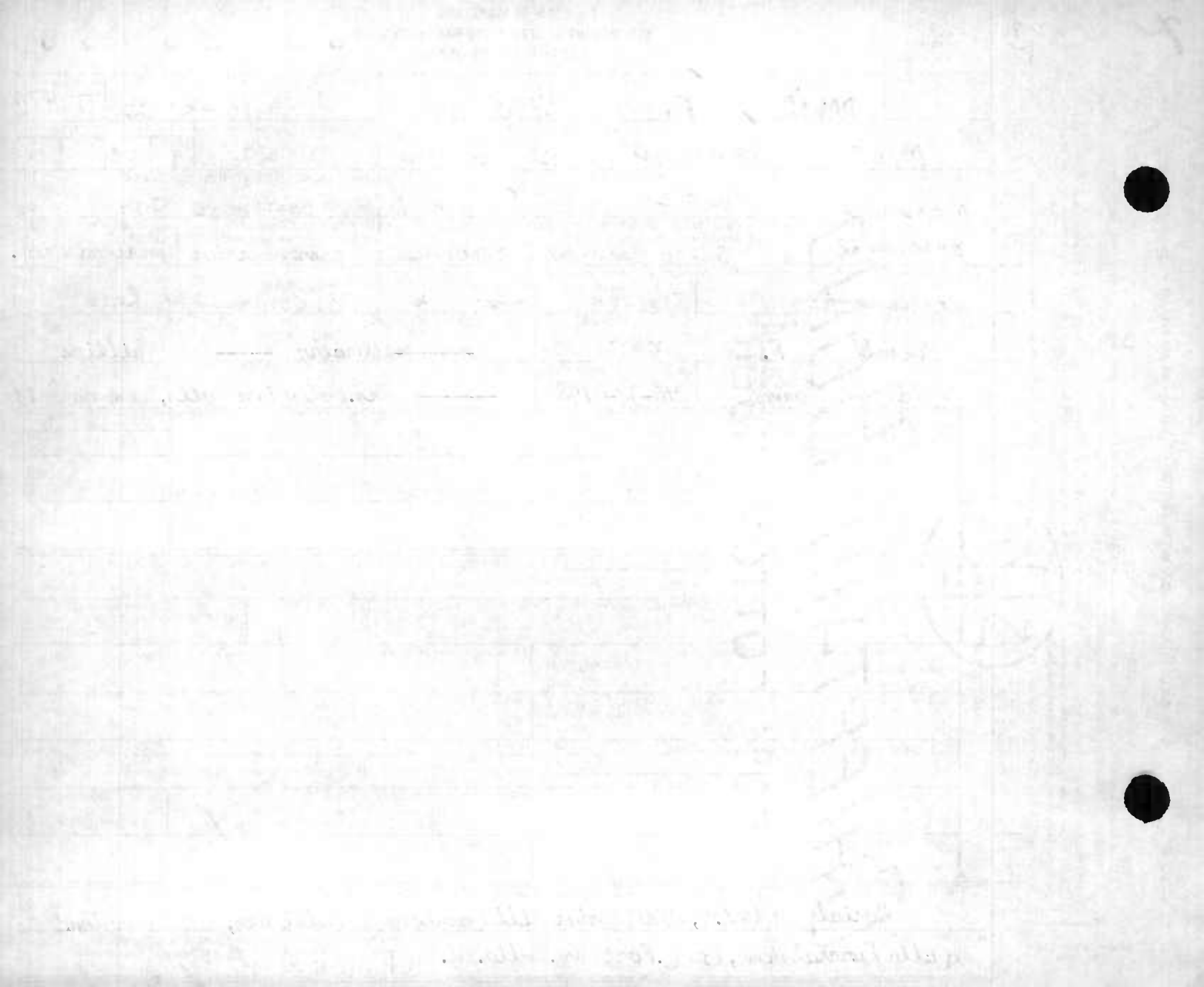
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 2 5 9 5 0   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| DAVID F. WATTS   |  |  |  | 10-6-80   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| MALE   |  | CAUCASIAN  |  | 12 29 32  |  | 47 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| MARYLAND   |  | U.S.A.   |  |   |  | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| BALTIMORE  |  | SOUTH BALTIMORE GENERAL  |  | (name operator)   |  | American Dreg.   |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| MARYLAND   |  |  |  | ANNE ARUNDEL  |  | SEVERNA  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| Russell F. WATTS   |  |  |  | Dorothy Phillips  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |
| Yes  |  |  |  | 216-30-6198   |  | Mrs. Betty Lou Watts, Same as # 13                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) RESPIRATORY FAILURE  |  |  |  |   |  |  |  |
| 1991   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |
| (b) METASTATIC SQUAMOUS CELL CARCINOMA   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |
| (c)  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |
|  |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 9/29/80 to 10/6/80, that (1) (we) lost saw the deceased alive on 10/6/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| J. Lowder M.D.   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 10/6/80  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  |
| LOWDER   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| Burial   |  | Oct. 9, 1980   |  | Cedar Hill Cemetery   |  | Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.  |  |  |  | OCT 7 1980  |  | [Signature]  |  |



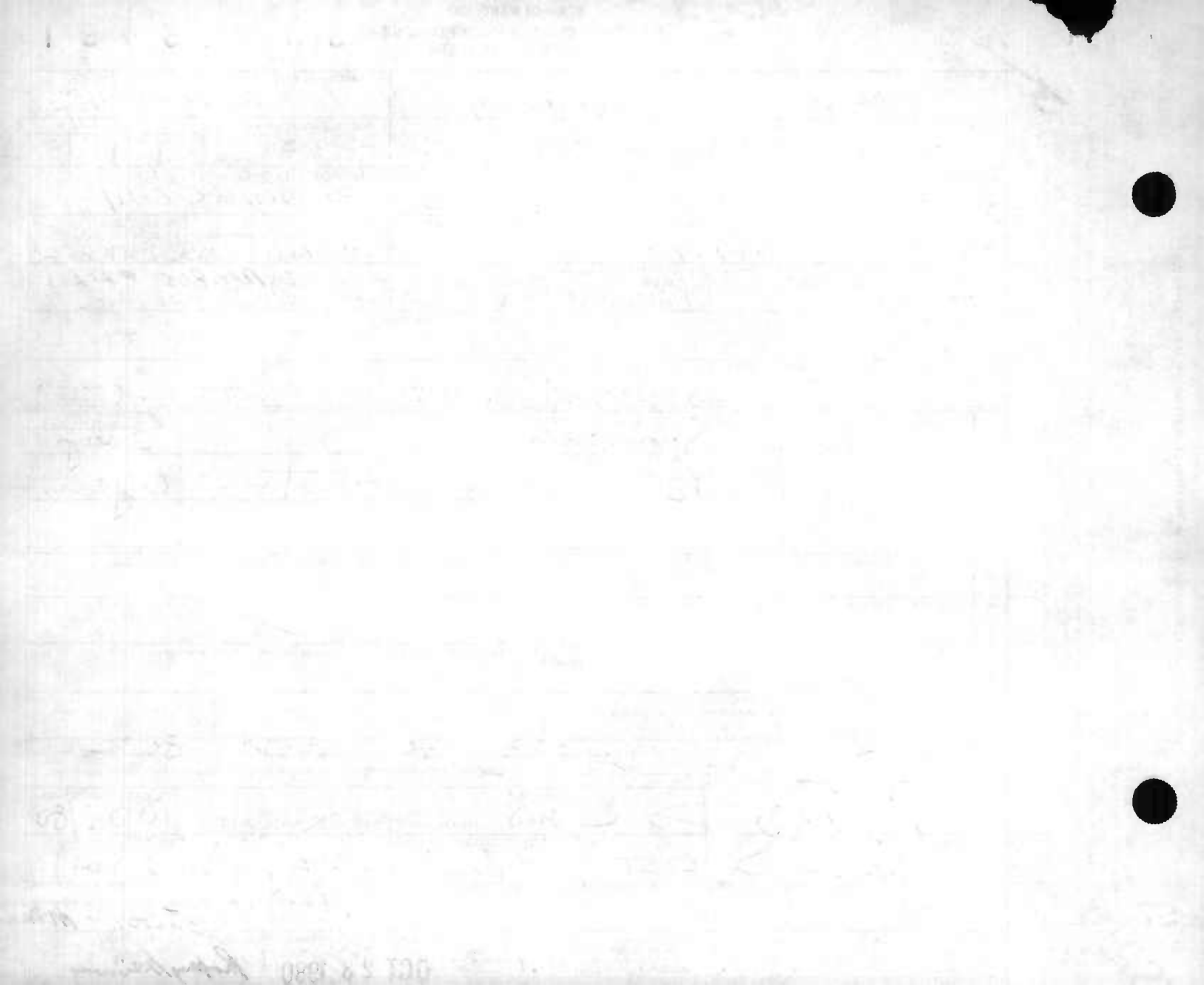
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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 80 25951  |  |  |   |
|---|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 10/24/80  |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose Weinberg  |  |   |  | 2b. HOUR 11:10 P.M.  |  |  |   |
| 3 SEX Female  |  | 4 RACE CAUCASIAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR 7/15/1905  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA  |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.  |   |
| 10. CITY OR TOWN OF DEATH BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEONDALE |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHICKEN BUSINESS BUTCHERY  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE MARYLAND   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN BALTIMORE  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY BROWN   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA NATINSKY   |  | 13e. STREET ADDRESS Apt. 805 #2/215 2500 W. Belvedere Ave.   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  | 16b. SOCIAL SECURITY NO. 367-34-9908  |  | 17. INFORMANT ADDRESS MRS. EVELYN NATHAN 3920 SYBIL RD. (21133)  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1749 Sepsis   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) Breast Cancer metastatic   |  |   |  |  |  |  | 6 years   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (this hospital) attended the deceased from 10-23-80 to 10-24-80, that (we) last saw the deceased alive on 10/24/80, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |   |  |  |  |  |   |
| 22b. SIGNATURE [Signature] M.D.   |  |   |  | 22c. DATE SIGNED 10/25/80  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NDC LIST   |   |
| 22e. ADDRESS Belvedere + Grosvenor AVE (21209)  |  |   |  | 22f. ADDRESS   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  | 23b. DATE 10/26/80  |  | 23c. NAME OF CEMETERY OR CREMATORY HAR SINAI   |  | 23d. LOCATION COWINGS MILLS MD. BALTO. MD  |   |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REGISTERSTOWN RD. BALTIMORE, MD. (21215)  |  |   |  | 25a. DATE REC'D. BY REGISTRAR OCT 28 1980  |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |   |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80 25952

REG. NO.

|   |         |   |  |   |      |   |   |
|---|---------|---|--|---|------|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |         | 2a. DATE OF DEATH   |  | MONTH   | DAY  | YEAR  | 2b. HOUR  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  | LAST |   |   |
| PHILIP  |         | WEISS   |  | 10 - 20 - 80  |      | 11:43 AM  |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |      | 7. IF UNDER 1 YEAR  |   |
| MALE  | WHITE   | MONTH DAY YEAR  |  | 72  |      | MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |
| NEW JERSEY  |         | USA   |  |   |      | BALTIMORE CITY MD.  |   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                       |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |
| BALTIMORE   |         | SINAI HOSPITAL  |  | BUTCHER   |      | RETAIL  |   |
| 13a. STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS?  |   |
| MARYLAND  |         | BALTO.  |  | BALTIMORE   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS   |      | 13f. CITY OR TOWN   |   |
| FIRST MIDDLE LAST   |         | FIRST MIDDLE LAST   |  | #3 CROYDON CT.  |      | #21207  |   |
| JOSEPH WEISS  |         | EVA ADLER   |  |   |      |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |      | 17a. ADDRESS  |   |
| NO  |         | 216-03-7983   |  | MRS. REBECCA WEISS  |      | #3 CROYDON CT. BALTO., MD 21207                                     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>410- -MYOCARDIAL INFARCTION</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>+</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASPIRATION PNEUMONIA</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |         |   |  |   |      |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3 days.</u> |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |   |
|   |         |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |      | YES <input type="checkbox"/> NO <input type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |      |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |      |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-17-1980</u> to <u>10-20-1980</u> , that (I) (we) last saw the deceased alive on <u>10-20-1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |         |   |  |   |      |   |   |
| 22b. SIGNATURE  |         | DEGREE  |  | 22c. DATE SIGNED  |      |   |   |
| <u>Asnani. 9159.</u>  |         | M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 10-20-80  |      |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         | 22e. ADDRESS  |  |   |      |   |   |
| Haresh Asnani   |         | SINAI HOSPITAL OF BALTO. MD.  |  |   |      |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |   |
| BURIAL  |         | OCT. 21, 1980   |  | RODFE ZEDEK   |      | BALTIMORE MARYLAND  |   |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |      |   |   |
| SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |         | OCT 22 1980   |  | <u>Rickey McCreedy</u>  |      |   |   |



NOTIFICATION

NOTIFICATION



✓

10/10/10

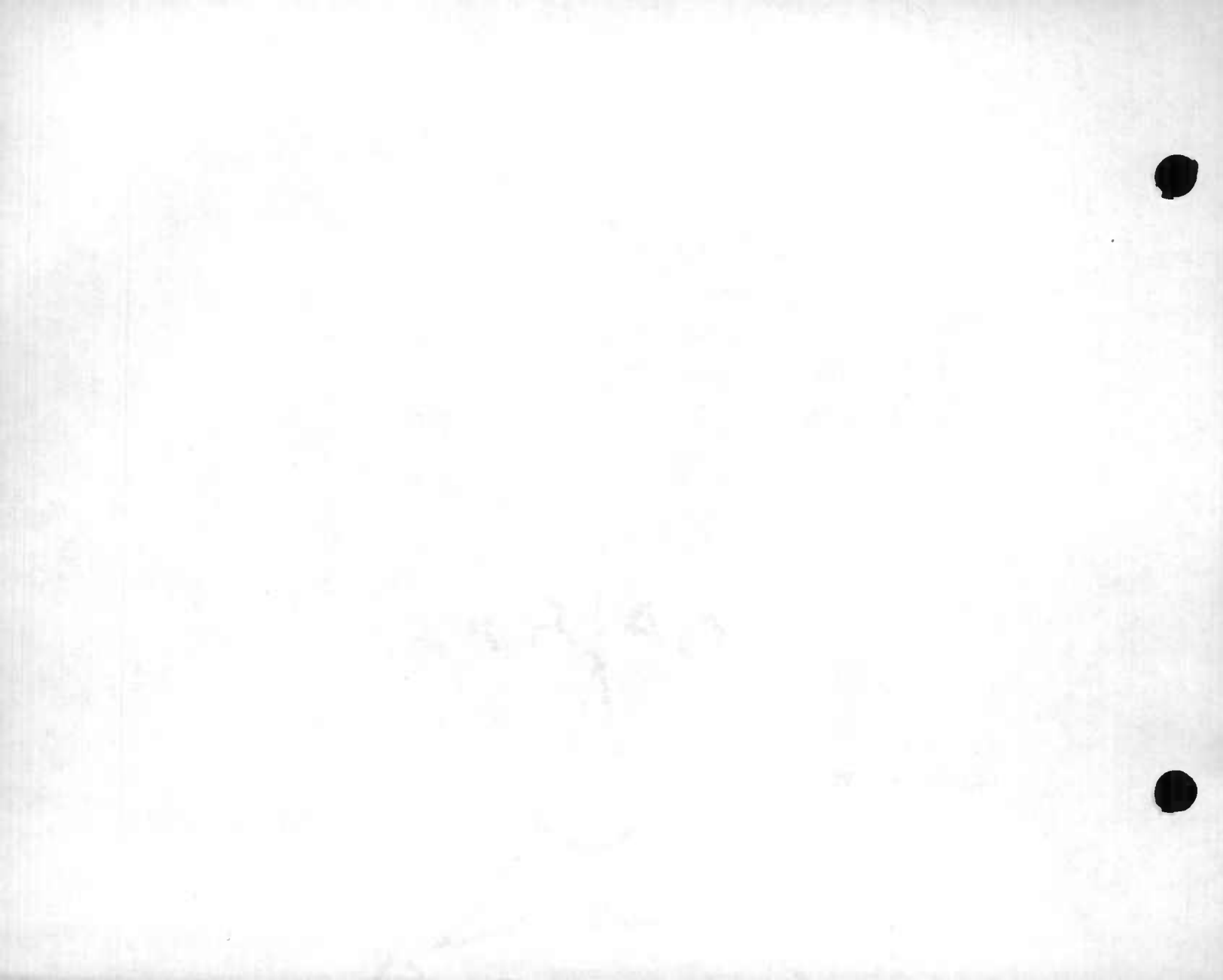
**NAME:** Gerald Marion West

**DATE OF DEATH:** October 9, 1980

**PLACE OF DEATH:** Baltimore City

**SEE:** #80-25801  
Baltimore City

DBMH 2485 - Vit. Rec.

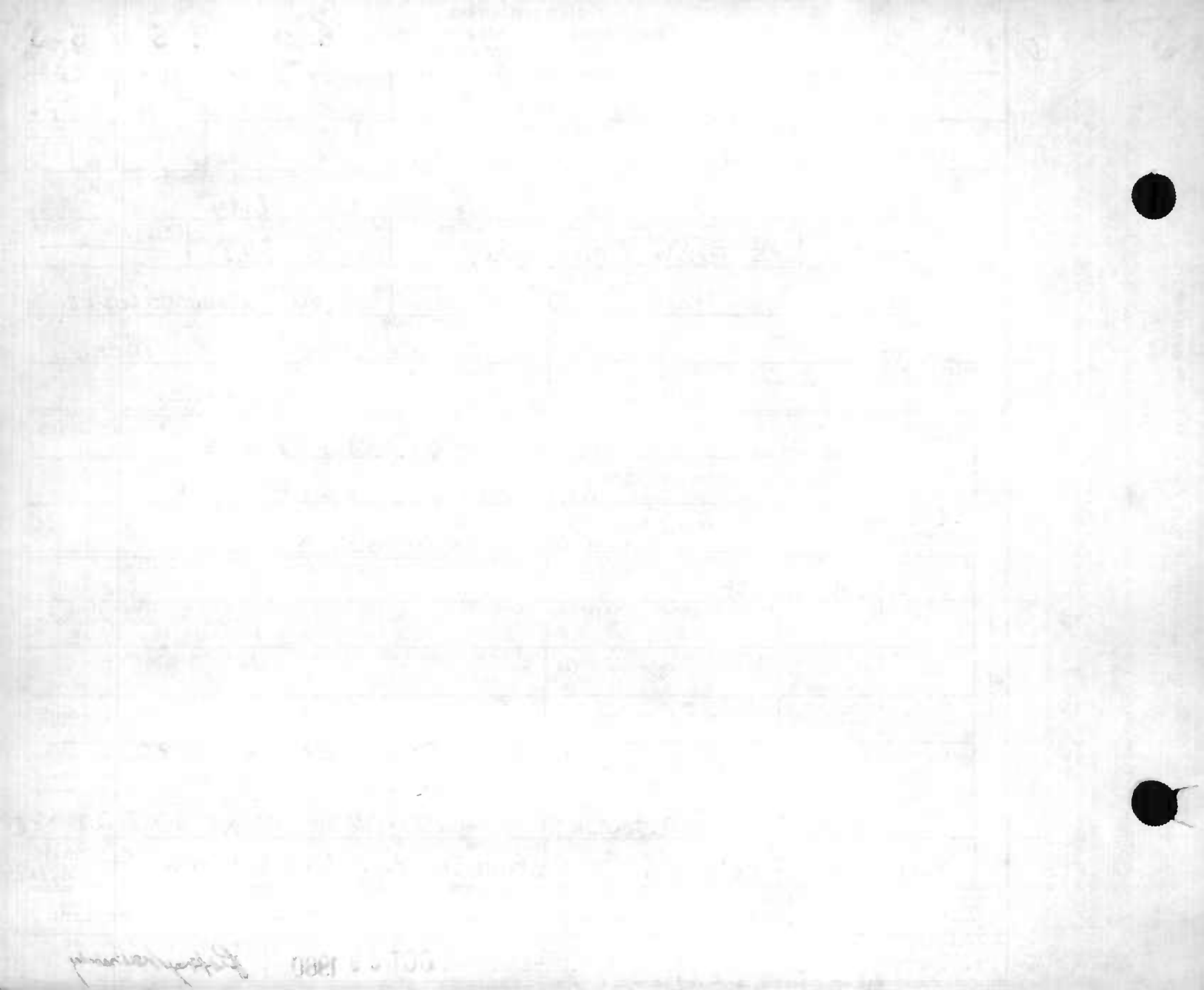


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |                                      |  |  |  | 8025953   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--------------------------------------|--|--|--|---|-----|--|----------|---|--|--|--|---------------------|--|---------------------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST                                 |  | 2a. DATE OF DEATH  |  | MONTH   | DAY | YEAR   | 2b. HOUR |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| David   |  | M   |  | White  |  |                                      |  | 10   |  | 27  | 80  | 240  | P.M.     |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)      |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| male  |  | Black   |  | MONTH DAY YEAR<br>8 30 30  |  | 50                                   |  | YRS  |  | MONTHS DAYS   |     | HOURS MIN.   |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| Virginia  |  | USA   |  |  |  | Balto. City MD.                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |                                      |  |  |  |   |     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |          | 12b. KIND OF BUSINESS OR INDUSTRY               |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| Balto.  |  | S. Balto. Gen'l. Hosp.  |  |  |  |                                      |  |  |  |   |     | on disability  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |                                      |  |  |  | 13a. STATE  |     | 13b. COUNTY  |          | 13c. CITY OR TOWN                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS |  |                                 |  |  |  |  |  |  |  |  |  |
|   |  |   |  |  |  |                                      |  |  |  | Md.   |     |  |          | Balto. 21225                                    |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  | 2834 Winwood Court  |  |                                 |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |   |  |  |  |                                      |  |  |  | 15. MOTHER'S MAIDEN NAME                                |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST<br>Luther   |  |   |  |  |  |                                      |  |  |  | FIRST MIDDLE LAST<br>Fannie Mae Mosley                  |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |  |  |                                      |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) |     |  |          |   |  |  |  |                     |  | 17. INFORMANT ADDRESS           |  |  |  |  |  |  |  |  |  |
|   |  |   |  |  |  |                                      |  |  |  | 224-32-7545   |     |  |          |   |  |  |  |                     |  | Tealar White 2834 Winwood Court |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.  |  |   |  |  |  |                                      |  |  |  |   |     |  |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) anoxic encephalopathy, severe   |  |   |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| (c) bilateral pneumonia   |  |   |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| EtOH abuse  |  |   |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                      |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from OCT. 4, 1980, to OCT. 27, 1980, that (I) (we) last saw the deceased alive on OCT. 27, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE   |  |                                      |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |     | 22c. DATE SIGNED   |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| Barbara Fretwell MD   |  |   |  |  |  |                                      |  |  |  |   |     | OCT. 27 '80  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| Barbara Fretwell  |  |   |  | S. Balto. Gen. Hosp. 3001 S. Hamover St. Balto. Md. 21230  |  |                                      |  |  |  |   |     |  |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   |  | 23b. DATE  |  |                                      |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| Burial  |  |   |  | 11/1/80  |  |                                      |  | Arbutus Cemetery   |  |   |     | Baltimore Maryland   |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |   |  | ADDRESS  |  |                                      |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |     | 25b. REGISTRAR'S SIGNATURE   |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |
| Wm. C. March Funeral Home Inc.  |  |   |  | 1101 E. North Avenue   |  |                                      |  | OCT 29 1980  |  |   |     | P. J. H. H. H.   |          |   |  |  |  |                     |  |                                 |  |  |  |  |  |  |  |  |  |



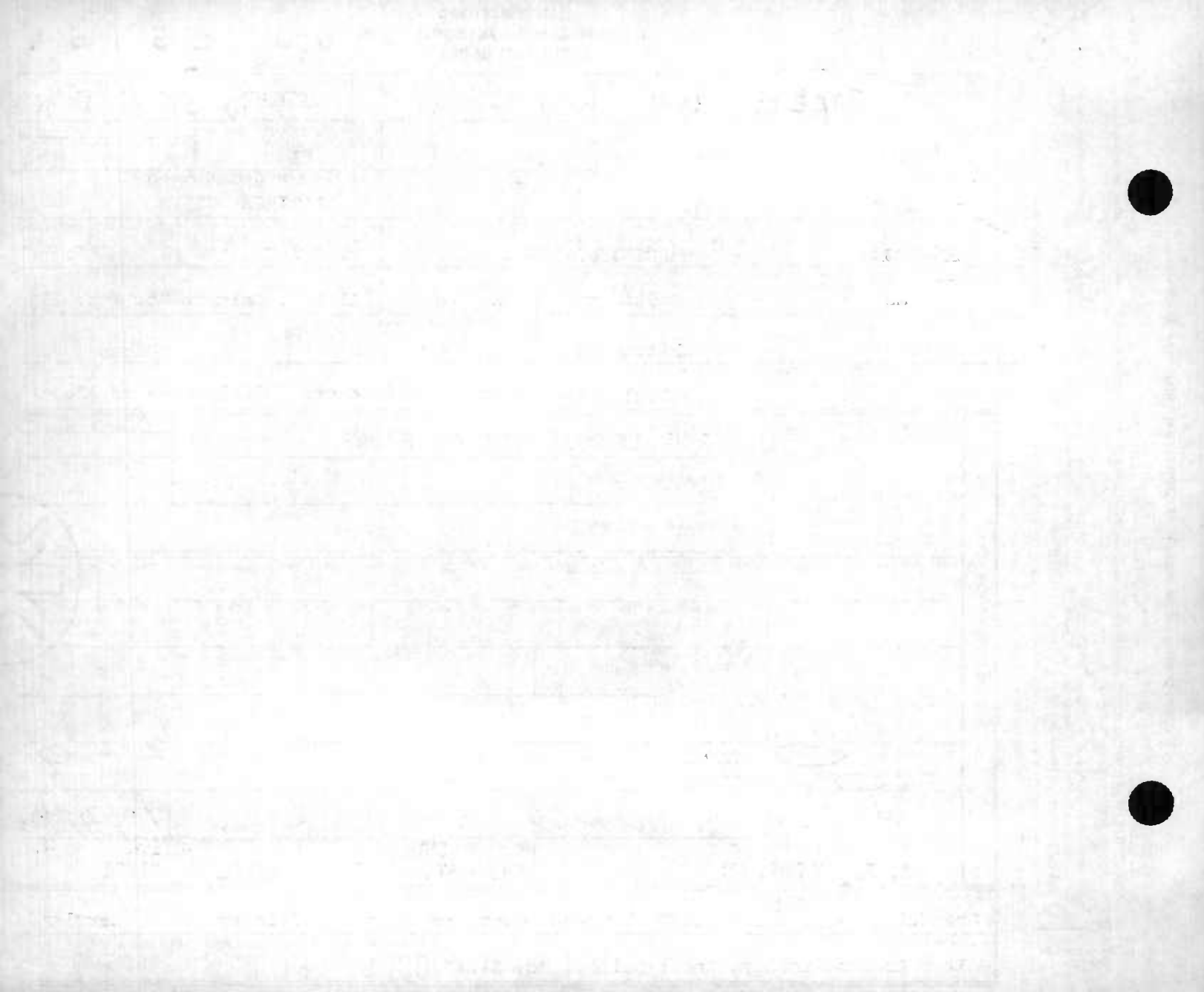
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 8025954  |  |        |  |                            |  |       |  |           |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--------|--|----------------------------|--|-------|--|-----------|--|
| 1. FOR STATE REGISTRAR  |  | EARLE  |  | MIDDLE   |  | LAST  |  | WHITE  |  | REG. NO.   |  |        |  |                            |  |       |  |           |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | WHITE <td colspan="2">2a. DATE OF DEATH</td> <td colspan="2">MONTH</td> <td colspan="2">DAY</td> <td colspan="2">YEAR</td> <td colspan="2">2b. HOUR</td> |  | 2a. DATE OF DEATH  |  | MONTH  |  | DAY                        |  | YEAR  |  | 2b. HOUR  |  |
| EARLE   |  | (nmi)  |  | WHITEMORE  |  | WHITEMORE   |  | WHITEMORE  |  | OCTOBER  |  | 10     |  | 04                         |  | 1980  |  | 8:10 A.M. |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  | MONTHS |  | DAYS                       |  | HOURS |  | MIN.      |  |
| MALE  |  | WHITE  |  | 05 06 99   |  | 81  |  | YRS.   |  |  |  |        |  |                            |  |       |  |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| MARYLAND  |  | U.S.A.   |  |  |  | BALTIMORE CITY  |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| Baltimore   |  | CHURCH HOSPITAL, INC.  |  | MUSICIAN   |  | ENTERTAINMENT   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |        |  |                            |  |       |  |           |  |
| Md.   |  | -----  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1101 N. Calvert St. Apt. 315   |  |  |  |        |  |                            |  |       |  |           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| FIRST   |  | MIDDLE   |  | LAST   |  | FIRST   |  | MIDDLE   |  | LAST   |  |        |  |                            |  |       |  |           |  |
| Edward  |  | Whittemore   |  | Mary   |  | Cohen   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| No  |  | 267.01.9819  |  | Flora B. Whittemore (Wife)   |  | Same as 13e   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |        |  |                            |  |       |  |           |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF LUNG   |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 1629 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| (c)   |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |  |  |        |  |                            |  |       |  |           |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE  |  |        |  |                            |  |       |  |           |  |
|   |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 22a. I certify that (I) this hospital attended the deceased from OCTOBER 1, 1980, to OCTOBER 4, 1980, that (I) (we) last saw the deceased alive on OCTOBER 4, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |        |  |                            |  |       |  |           |  |
| 22b. SIGNATURE  |  |  |  |  |  |   |  |  |  | DEGREE   |  |        |  | 22c. DATE SIGNED           |  |       |  |           |  |
| A. F. Nazemi, MD  |  |  |  |  |  |   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |        |  | OCTOBER 4, 1980            |  |       |  |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  |   |  |  |  | 22e. ADDRESS   |  |        |  |                            |  |       |  |           |  |
| A. F. NAZEMI, MD  |  |  |  |  |  |   |  |  |  | CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231  |  |        |  |                            |  |       |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY   |  | STATE  |  |        |  |                            |  |       |  |           |  |
| Cremation   |  | 10/6/1980  |  | Green Mount Crematory  |  | Baltimore   |  | Maryland   |  |  |  |        |  |                            |  |       |  |           |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  |  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |        |  | 25b. REGISTRAR'S SIGNATURE |  |       |  |           |  |
| Walter Brooks Bradley, Inc., Balto., Md. 21222  |  |  |  |  |  |   |  |  |  | OCT 9 1980   |  |        |  | Walter Brooks Bradley      |  |       |  |           |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   | 8 0 2 5 9 5 5<br>REG. NO.   |  |  |  |                            |
|--|--|---|---|---|--|--|--|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RAYMOND WIENER</b>   |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 15 80</b>  |  |  |  | 2b. HOUR<br><b>2-36 PM</b> |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>W HITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 15 1896</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84 YRS.</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>     |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |  |                            |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL OF BALTO.</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MERCHANT</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>   |  |                            |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>16 MILLSTONE RD. 21133</b> |  |  |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERMAN - WIENER</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DEBRA - UNKNOWN</b> |   |  |  |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-32-5530</b>  |   | 17. INFORMANT <b>MRS. GLORIA BEIDEL</b><br><b>16 MILLSTONE RD., RANDALLSTOWN, MD 21133</b>      |  |  |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>410 - Acute myocardial Infarction.</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>+ Pericarditis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days.</b> |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |   |   |  |  |  |                            |
| 19a. DATE OF OPERATION<br><b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-14-</b> 19 <b>80</b> , to <b>10-15-</b> 19 <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10-15-</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |   |   |   |  |  |  |                            |
| 22b. SIGNATURE<br><b>Asnani. 9159.</b>   |  | DEGREE<br><b>MD.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>10-15-80</b>  |  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Haresh Asnani.</b>   |  | 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTO. MD.</b>   |   |   |  |  |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>OCT. 17, 1980</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI ISRAEL</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTIMORE MARYLAND</b>  |  |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS. INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 22 1980</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |                            |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 0 2 5 9 5 6<br>REG. NO.  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Luzzetta M. Willey</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 4-1980</b>  |  | 2b. HOUR<br><b>2:15 PM</b>   |   |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 1, 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |   |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Howard</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jefferson</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Luzzetta Smith</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-3892</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Luzzetta F. Duerr Vienna, W. V. 26105</b>             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiorespiratory arrest</b><br><b>410-</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>coronary heart dis.</b>  |  |   |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-2</b> , 19 <b>80</b> , to <b>10-3</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-3</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Kareem Said</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Kareem Said</b>  |  |   |  | 22e. ADDRESS<br><b>St Agnes Hospital</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/6/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Groten Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hallwood Accomack Va.</b>           |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Scott S. Milson</b>   |  |   |  | ADDRESS<br><b>Pocomoke City, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>0618 1980</b>                                    |   |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |   |

BALTIMORE CITY

ST. JAMES HOSPITAL

BALTIMORE

HSIT

1944

1944

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 2 5 9 5 7  
REG. NO.1 - FOR  
STATE  
REGISTRAR

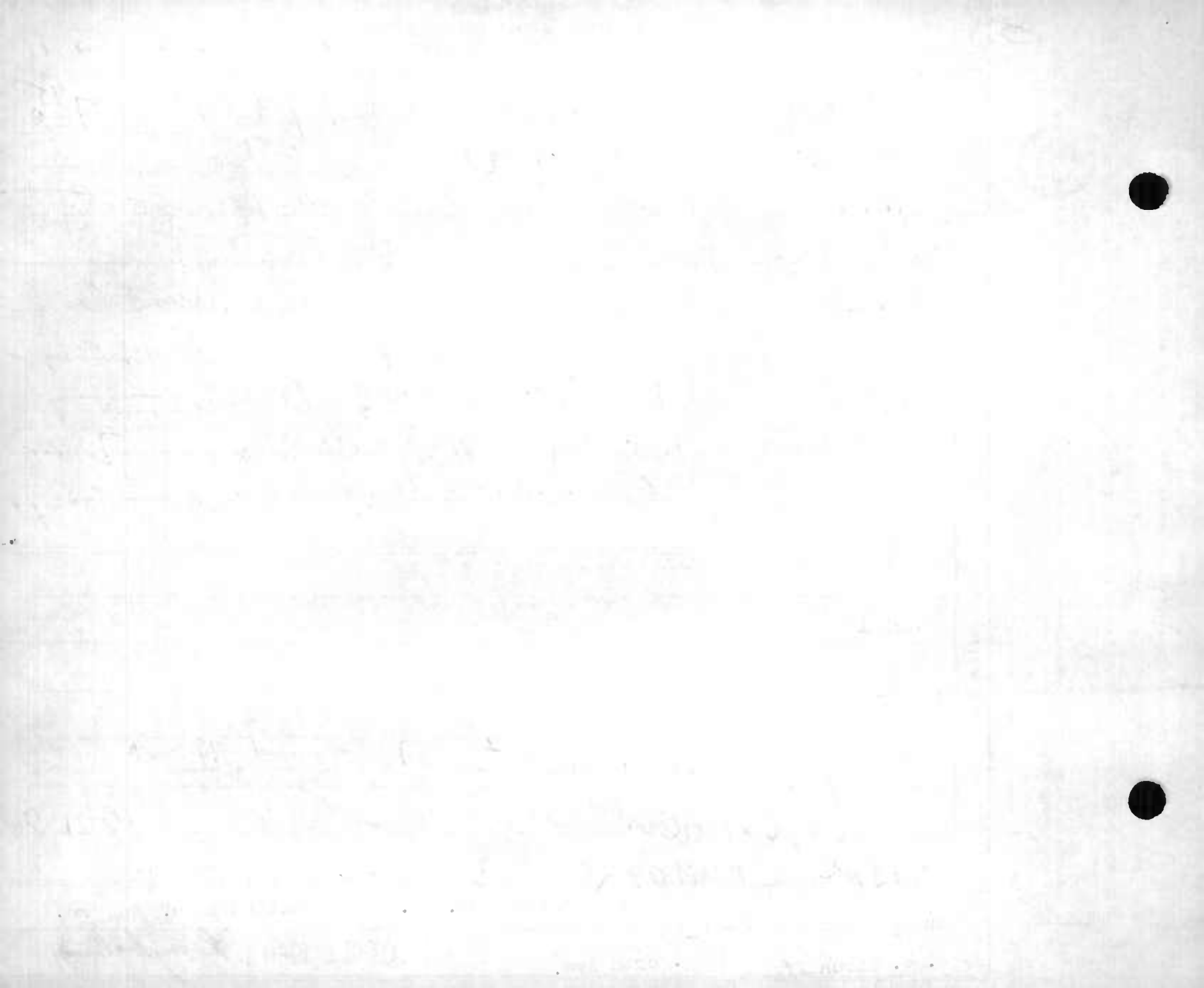
|   |  |   |   |  |
|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Betty Williams   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/19/80   |   | 2b. HOUR<br>7:45 PM  |
| 3. SEX<br>Female  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7/20/40   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>40 YRS                                      |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Providence                                     |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Unemployed |
| 13a. RESIDENCE<br>13a-1 STATE<br>MD   | 13a-2 NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION<br>13b. COUNTY<br>Baltimore | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>1600 Mount Royal  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>DAN HUTCHINSON  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DAN HUTCHINSON   |   | 16. SOCIAL SECURITY NO.<br>21438447  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 18. INFORMANT<br>ADDRESS<br>CHURCH - Providence Hosp  |   |  |
| 19. CAUSE OF DEATH: Enter only one cause per line for 19a, 19b and 19c.<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction,</u><br>410 - DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>2 yrs 3-5 yrs</u> |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1</u>   |  |   |   |  |
| 19a. DATE OF OPERATION<br>Burial  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  |
| 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)  |   |  |
| 21d. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. DATE SIGNED<br>10/21/80  |   |  |
| 22b. SIGNATURE<br>E. J. SAUNDERS  |  | 22c. DATE SIGNED<br>10/21/80  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAUNDERS                              |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>10-24-80   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. Pk.                         |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD.   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>OCT 21 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>Robert McCreedy   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR<br>STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 0 2 5 9 5 8   |  |  |  | REG. NO.   |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLARENCE WILLIAMS</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 14 80</b>  |  | 2b. HOUR<br><b>5:00 a.m.</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 25 1896</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>84 YRS.</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER BALTO. MD.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charlie Williams</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Genia Rachelle</b>  |  | 13e. STREET ADDRESS<br><b>401 E. 25 Street Balto. 21218</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW I</b>   |  | 17. INFORMANT<br><b>Hattie McClary</b>  |  | ADDRESS<br><b>2610 Quantico Ave.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>4280</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Severe Emaciation</b><br>(c) <b>Chronic Congestive Heart Failure.</b>   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |
| <b>None</b>   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCT. 8,</b> 19 <b>80</b> , to <b>OCT. 14,</b> 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost <b>view of the deceased upon or about OCT. 14,</b> 19 <b>80</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <b>not</b> view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Robert Benson Hunt MD</b>  |  |  |  |   |  |  |  | 22c. DATE SIGNED<br><b>10/14/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Benson Hunt MD</b>   |  |  |  |   |  |  |  | 22e. ADDRESS<br><b>Loch Raven VA Hospital</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>10/18/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 15 1980</b>                                  |  |
| 24. FUNERAL DIRECTOR<br><b>WM. C. MARCH F/H</b>   |  | 1101 E. NORTH AVE.   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Harry McHenry</b>  |  |  |  |  |  |

REC-2 CB ME CF

## EXHIBIT

#6, 16b G548 10/16/80 bal

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
|--|--|--|--|--|--|---|--|--|--|------------------|--|--------------------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE KNOWN OF DEATH                      |  | ESTIMATED        |  | MONTH                                |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| JAMES  |  | A.   |  | WILLIAMS   |  |   |  | 10   |  | 4                |  | 19                                   |  | 80    |  |      |  | M        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                               |  | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD             |  | MONTH |  | DAY  |  | YEAR     |  |
| male   |  | negro  |  | 2 13 40  |  | 39 40 YRS.  |  |  |  |                  |  | 10                                   |  | 4     |  | 19   |  | 80       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED   |  | NEVER MARRIED   |  | WIDOWED                                      |  | DIVORCED         |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |       |  |      |  | MD.      |  |
| VA.  |  | USA  |  | X  |  |   |  |  |  |                  |  | Baltimore City                       |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| Baltimore  |  | 5508 Silverbell Rd.  |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                  |  |                                      |  |       |  |      |  |          |  |
| MD   |  |  |  | Baltimore  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 2835 the Alameda                             |  |                  |  |                                      |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| Henry  |  | Ethel  |  | Williams   |  | Jones   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| No   |  | 220-38-6713  |  | Shirley M. Williams  |  | 2835 The Alameda  |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | PART 1 DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                  |  |                                      |  |       |  |      |  |          |  |
| 4254   |  | Cardiomyopathy   |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
|  |  |  |  | (c)  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).                      |  |  |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
|  |  | P.M. 19  |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY                                       |  | STATE            |  |                                      |  |       |  |      |  |          |  |
|  |  |  |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:   |  | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE   |  | TITLE (SPECIFY)  |  | DATE SIGNED  |  | 10-4-80   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| Ann M. Dixon, M.D.   |  | Assistant  |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  | ADDRESS  |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
|  |  | 111 Penn St.   |  |  |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY                                       |  | STATE            |  |                                      |  |       |  |      |  |          |  |
| Burial   |  | 10/10/80   |  | Balto. Cem.  |  | Balto. City   |  |  |  | Md.              |  |                                      |  |       |  |      |  |          |  |
| 24. FUNERAL HOME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |
| Wm. C. March F/H. 1101 E. North Ave.   |  | OCT 7 1980   |  | Dixie M. Brady   |  |   |  |  |  |                  |  |                                      |  |       |  |      |  |          |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 0 2 5 9 6 0

|   |  |  |  |  |                                       |  |
|---|--|--|--|--|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JESSE E WILLIAMS, Sr.</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 11 80</b> |  | 2b. HOUR<br><b>12:00a<sub>M</sub></b> |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 1 15</b>  |                                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                        |  | 8. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                       |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC BALTIMORE, MARYLAND 21218</b> |                                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |                                       |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1100 BOLTON STREET</b>                                   |  |  |                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH WILLIAMS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY Ireland</b>               |  |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 219 14 2128</b> |  | 17. INFORMANT<br>ADDRESS<br><b>Jesse E. Williams, Jr. 4006 Spruce Dr.</b>  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>Sepsis</b><br>0381<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b): <b>Staphylococcus infx</b><br>DUE TO, OR AS A CONSEQUENCE OF (c):<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>G.I. Bleed, SS Sx &amp; pacemaker, PVD &amp; Fem-Fem by pass, AKA Amputation, Dementia</b>   |  |  |  |  |                                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                       |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>SEPTEMBER 9</b> , 19 <b>80</b> , to <b>OCTOBER</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>OCTOBER 11</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |  |  |                                       |  |
| 22b. SIGNATURE<br><b>Alvin R. Sills MD</b>  |  | DEGREE   |  | 22c. DATE SIGNED   |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Alvin R. Sills MD</b>   |  | 22e. ADDRESS<br><b>Arbutus Mem. Pk.</b>  |  |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/17/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>  |                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md</b>  |  |  |  |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>   |  | ADDRESS<br><b>1101 E. North Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |                                       |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert M. Bundy</b>   |                                       |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 6 1

REG. NO.

|  |  |   |  |   |  |   |  |  |   |
|--|--|---|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Leola F. Williams</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 8, 1980</b>          |   |  | 2b. HOUR MIN<br><b>4:20 PM</b>  |  |  |   |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 9, 1893</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                                |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Long Green Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>USPH Hospital</b>  |   |
| 13a. STATE<br><b>Md</b>  |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>2601 Taney Road 21209</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joshua Hanes</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Roberta Baggerly</b>  |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220 34 6443</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Shirley Andoniades</b>   |  |   | Same   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>C. V. A.</b><br><b>436 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:18 PM 1980</b> |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>5118 Oct 8 80</b>                       |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 6 1980</b> to <b>Oct 8 1980</b> , that (I) (we) last saw the deceased alive on <b>Oct 6 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (saw) the body after death.   |  |   |  |   |  |   |  |  |   |
| 27b. SIGNATURE<br><b>William Helfrich</b> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |  | 27c. DATE SIGNED<br><b>10/10/80</b>   |  |  |   |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>William Helfrich</b>   |  |   |  |   |  | 27e. ADDRESS<br><b>5006 Roland Avenue</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>10/11/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Pleasant Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Gambers Carroll Md.</b> |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Burgee Funeral Home</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 10 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |
| 26. ADDRESS<br><b>3631 Falls Road 21211</b>  |  |   |  |   |  |   |  |  |   |

October 8, 1960

April 2, 1962

Baltimore City

USIA Head

South Tower Road

Robert Murphy

220 3d only Shirley Anderson

2000 Notary Avenue

10/11/60

1960

FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |  |        |  |                                  |   |                                   |   |                                   |   |  |       |
|---|---------|--|--------|--|----------------------------------|---|-----------------------------------|---|-----------------------------------|---|--|-------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  | MIDDLE | LAST   | 2a. DATE KNOWN OF DEATH          |   | MONTH                             |   | DAY                               | YEAR  | 2b. HOUR                                     |       |
| William McKinley Williams   |         |  |        |  | 10 24 19 80                      |   |                                   |   |                                   |   | M  |       |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |        | 6. AGE (IN YEARS)<br>LAST BIRTHDAY   | 7. IF UNDER 1 YR.<br>MONTHS DAYS |   | 8. IF UNDER 24 HRS.<br>HOURS MIN. |   | 9. DATE PRONOUNCED DEAD           |   | 24. HOUR                                     |       |
| male  | negro   | 10 17 13   |        | 67 YRS.  |                                  |   |                                   |   | 10 29 19 80                       |   | 11:20 a M                                    |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |                                   |   |                                   |   |  |       |
| VA  |         | USA  |        |  |                                  | Baltimore City MD.  |                                   |   |                                   |   |  |       |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |        |  |                                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |       |
| Baltimore   |         | 415 E. Chase St.   |        |  |                                  |   |                                   |   |                                   |   |  |       |
| 13a. STATE  |         |  |        | 13b. COUNTY  |                                  | 13c. CITY OR TOWN   |                                   | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS   |  |       |
| MD  |         |  |        |  |                                  | Baltimore   |                                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 415 E. Chase St.  |  |       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |         |  |        | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                                  |   |                                   |   |                                   |   |  |       |
| Robert J. Williams  |         |  |        | Willy Ann Snead  |                                  |   |                                   |   |                                   |   |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |         |  |        | 16b. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT ADDRESS   |                                   |   |                                   |   |  |       |
| No  |         |  |        | 224-26-6697  |                                  | Barbara Peterson 524 Winston Ave.   |                                   |   |                                   |   |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |         |  |        |  |                                  |   |                                   |   |                                   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |        |  |                                  |   |                                   |   |                                   |   |  |       |
| 19a. DATE OF OPERATION  |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                  |   |                                   |   |                                   | 20. AUTOPSY?  |  |       |
|   |         |  |        |  |                                  |   |                                   |   |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |       |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |                                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                   |   |                                   |   |  |       |
|   |         |  |        | P.M. 19  |                                  |   |                                   |   |                                   |   |  |       |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                  | 21f. LOCATION<br>STREET   |                                   | CITY OR TOWN  |                                   | COUNTY  |  | STATE |
|   |         |  |        |  |                                  |   |                                   |   |                                   |   |  |       |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |         |  |        |  |                                  |   |                                   |   |                                   |   |  |       |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u>   |         |  |        | TITLE (SPECIFY) <u>Assistant</u>   |                                  |   |                                   | DATE SIGNED <u>10-29-80</u>   |                                   |   |  |       |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Virginia L. Dolan, M.D.</u>  |         |  |        | ADDRESS <u>111 Penn St.</u>  |                                  |   |                                   |   |                                   |   |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         |  |        | 23b. DATE  |                                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                   | 23d. LOCATION<br>CITY OR TOWN                                       |                                   | COUNTY  |  | STATE |
| Burial  |         |  |        | 11/3/80  |                                  | Cedar Hill Cem.   |                                   | Baltimore   |                                   | Co.   |  | MD    |
| 24. FUNERAL DIRECTOR<br>NAME  |         |  |        | ADDRESS  |                                  | 25a. DATE REC'D. BY REGISTRAR   |                                   | 25b. REGISTRAR'S SIGNATURE  |                                   |   |  |       |
| Wm. C. March F/H  |         |  |        | 1101 E. North Ave.   |                                  | NOV 5 1980  |                                   | <u>Richard M. [Signature]</u>                                       |                                   |   |  |       |

1911



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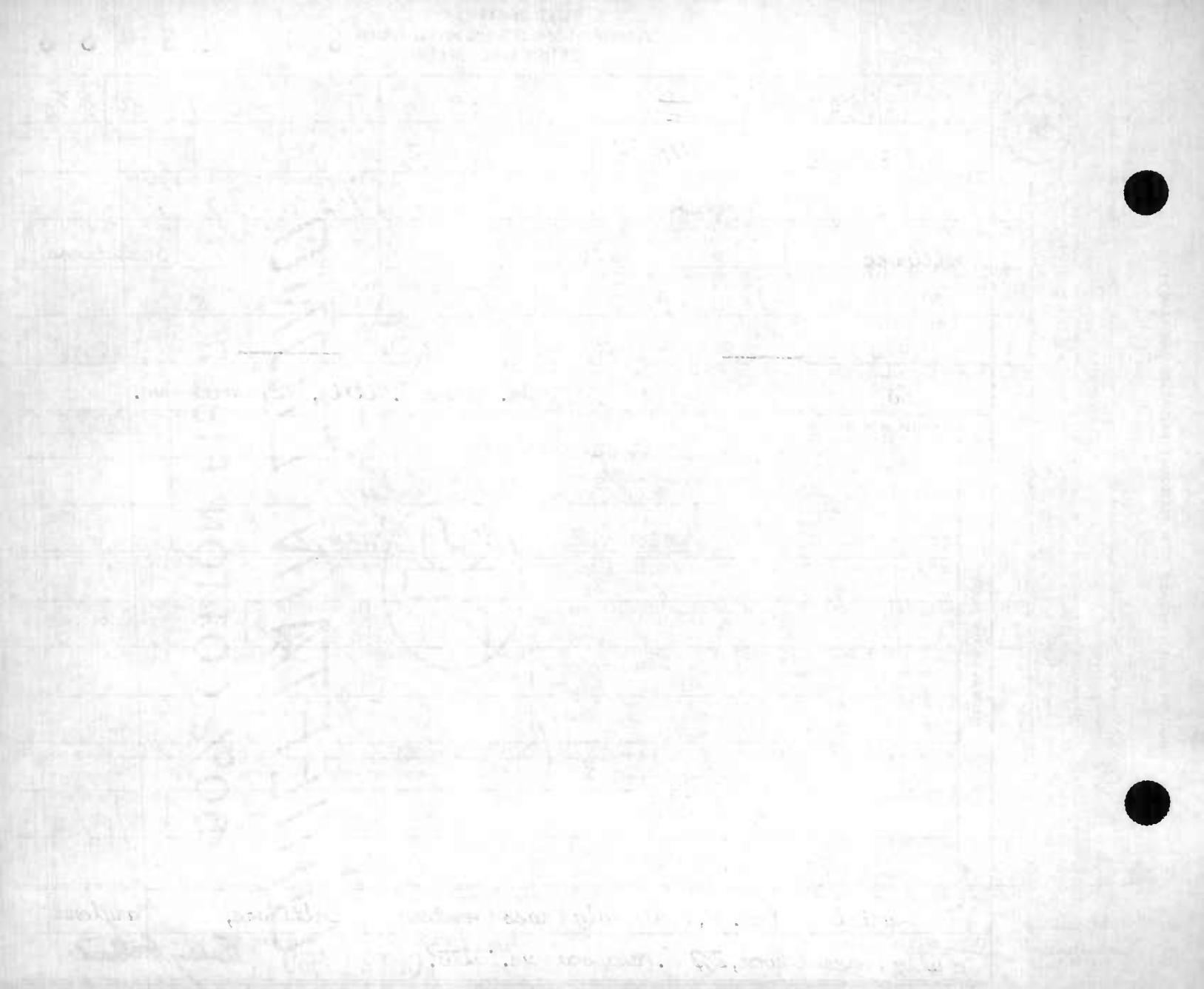


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |                          |  |  |
|--|--|--|--|---|---|--|--------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 8 0 2 5 9 6 3<br>REG. NO.  |  |   |   |  |                          |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA MARIE WILLIS</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>19</b> YEAR <b>80</b>                               |  | 2b. HOUR <b>8 35 A</b> M |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>18</b> YEAR <b>06</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.  |                          | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MO</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.   |                          |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SBGH</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Seamstress</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  |  |
| 13a. STATE<br><b>MO</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |   | 13e. STREET ADDRESS<br><b>4134 6th St.</b>   |                          |  |  |
| 14. FATHER'S NAME<br>FIRST <b>JOHN</b> MIDDLE <b>---</b> LAST <b>RICHARDSON</b>  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARY</b> MIDDLE <b>---</b> LAST <b>WARD</b>                |  |                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>21203 5578</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. George A. Willis, 4125 Doris Ave.</b>   |   |  |                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>3989</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Rheumatic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |  |                          |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |                          |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                          |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> , 19 <b>80</b> , to <b>10/19</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/19</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |                          |  |  |
| 22b. SIGNATURE<br><b>Steven Rapp</b>   |  |  |  | DEGREE<br><b>MD</b>   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                          | 22c. DATE SIGNED<br><b>10/19/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>STEVEN RAPP</b>  |  |  |  | 22e. ADDRESS<br><b>SBGH</b>   |   |  |                          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Oct. 22, 1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  |   | 23d. LOCATION<br>CITY <b>Baltimore</b> COUNTY <b>Maryland</b> STATE <b></b>  |                          |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>McCutty Funeral Home</b> ADDRESS <b>230 E. Patapsco Ave. Balto.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 21 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lester McCreedy</b>   |                          |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | 8 0 2 5 9 6 4   |  |  |  |
|---|--|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |   |  |  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES W. WILSON</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 20 1980</b>  |  |  |  | 2b. HOUR<br><b>4:40</b> M   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 11, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84 yrs</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNION MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY<br><b>-</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>1432 Union Avenue (21211)</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Abraham Wilson</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unknown</b>   |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>- -</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Helen George-1339 W. 41st Street</b>   |  |  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>inadequate respirations with congestion and hypoxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>chronic obstructive pulmonary disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>4 days</b><br><b>many years</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>adult onset diabetes mellitus, renal failure, congestive heart failure</b>  |  |   |  |   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 19, 1980</b> , to <b>October 20, 1980</b> , that (I) (we) lost saw the deceased alive on <b>October 19, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>B.R. Houston M.D.</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>10-20-80</b>  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B.R. HOUSTON M.D.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>10/23/80</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Grove Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>Rayville, Balto Co, Maryland</b>  |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>A. Alan Seitz Funeral Home 3816 Roland Ave.</b>  |  |   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>OCT 21 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>L. J. Kelly</b>   |  |   |  |  |  |

|   |               |           |         |
|---|---------------|-----------|---------|
| 60 yrs                                      | Nov. 11, 1896 | white     | Male    |
| RETIRED                                     | x             | U.S.A.    | Married |
| Retired                                     |               |           |         |
| 1132 Union Avenue (2181)                    | x             | Baltimore | Married |
| Unknown                                     |               | Wilson    | Arthur  |
| 217-07-459 Helen George-1132 W. 11th Street |               |           | No      |

OCT 31 1980  
 Pine Grove Cemetery, Baltimore Co., Maryland  
 10/23/80  
 10/23/80  
 10/23/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 6 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Cora B. Wilson</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>October 18, 1980</b>                                  |   | 2b. HOUR<br><b>8:00a M</b>                |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 13 00</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Bel Air Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.             |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)              | 12b. KIND OF BUSINESS OR INDUSTRY         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                       |   |   |   |   |   |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>3806 Bonner Rd. 21216</b>                           |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Louis Armstrong</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia Curtis</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |   | 16b. SOCIAL SECURITY NO.<br><b>214-18-6150</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Bernard M. Armstrong 3806 Bonner Rd. 21216</b> |   |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardio vascular accident**

4292  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Aspiration - probable**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/18</b> , 19 <b>80</b> , to <b>10/18</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) last<br>saw the deceased alive on <b>10/18</b> , 19 <b>80</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Eric Fisher</b>  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>10/18/80</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Eric Fisher, M.D.</b>   |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>                   |  |  |   |

|   |                              |   |   |
|---|------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>         | 23b. DATE<br><b>10/23/80</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Eternal Hope</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March Funeral Home Inc.</b> |                              | ADDRESS<br><b>1101 E. North Ave</b>                                 | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 20 1980</b>                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1-11-1911

1-11-1911

6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

084-27-623

WILSON, EVELYN

2553 BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 5 9 6 6   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>EVELYN A. WILSON</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/11/80</b>  |  | 2b. HOUR<br><b>12:18 PM</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 15 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>REGISTRAR</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOSPITAL</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  |  | 13b. COUNTY<br><b>---</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN THOMAS DRURY</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNIE WOODEN</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-10-0800</b>  |  | 17. INFORMANT ADDRESS<br><b>EVELYN A. REGAN 32 ELM DRIVE, GLEN BURNIE</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory failure</b><br><b>5339</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>perforated peptic ulcer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 DAYS</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>COPD</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>10/6/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>perforated peptic ulcer</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/6/80</b> , 19 <b>80</b> , to <b>10/11/80</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>10/11/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Herbert Lapor MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>10/11/80</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HERBERT LAPOR MD.</b>   |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-14-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>   |  |  |  | ADDRESS<br><b>21229 4107 WILKENS AVE.</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>   |  |

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "STATION" and "OFFICE" are visible.]*

STATION  
OFFICE  
SVA BUREAU

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

80

25967

REG. NO.

|  |   |   |  |   |   |  |   |                   |
|--|---|---|--|---|---|--|---|-------------------|
| 1. FOR<br>STATE<br>REGISTRAR   |   | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>HENRY  | MIDDLE<br>ALTHENS                         | LAST<br>WILSON   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/30/80 | 2b. HOUR<br>9:10a |
| 3. SEX<br>Male   | 4. RACE<br>Negro  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 9 23  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.             | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN.   |   |                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY |   |   | MD.  |   |                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |                   |
| 13a. STATE<br>MD   |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2809 Walbrook Ave. |  |   |                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Wilson   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie Johnson   |  |   |   |  |   |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes  |   | 16b. SOCIAL SECURITY NO.<br>215-12-2754   |  | 17. INFORMANT ADDRESS<br>Eleanor Mutcison 2809 Walbrook Ave.                                    |   |  |   |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>INTRACEREBRAL BLEED</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MESENCHYMAL CAT CELL CANCER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12 HOURS</u><br><u>5-6 MO.</u> |   |   |  |   |   |  |   |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |   |   |  |   |   |  |   |                   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |   |                   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |                   |
| 22a. I certify that (this hospital) attended the deceased from <u>OCTOBER 14</u> , 19 <u>80</u> , to <u>OCTOBER 30</u> , 19 <u>80</u> , that (we) lost saw the deceased alive on <u>OCTOBER 22</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.   |   |   |  |   |   |  |   |                   |
| 22b. SIGNATURE<br><u>Robert J. Mandel</u>  |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c. DATE SIGNED<br>10-30-80  |   |  |   |                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT J. MANDEL  |   | 22e. ADDRESS<br>601 N. BROADWAY, BALT MD. 21205   |  |   |   |  |   |                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>11/5/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cheltenham VA Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cheltenham MD  |   |                   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |   |   |  | ADDRESS<br>1101 E. North Ave.   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1980  |   |                   |
|  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |  |   |                   |

501:7

507:5

11 00 51  
11 00 51  
11 00 51

CCNY 5 5/10



3

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0

2 5 9 6 8

REG. NO.

|  |                         |  |  |   |   |
|--|-------------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SEARS - WILSON</b>  |                         |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>14</b> YEAR <b>80</b>                          |   | 2b. HOUR<br><b>12:30 P.M.</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>10</b> YEAR <b>12</b>                                 |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>GEORGIA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |                         |  | 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |   |   |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIVERSITY OF MD. HOSPITAL</b>   |                         |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SSI - disabled</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>—  |
| 13a. STATE<br><b>MARYLAND</b>  |                         |  | 13b. COUNTY<br><b>BALTIMORE CITY</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <b>unknown</b> MIDDLE <b>unknown</b> LAST <b>unknown</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>unknown</b> MIDDLE <b>unknown</b> LAST <b>unknown</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>unknown</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>218-07-1550</b>   |  | 17. INFORMANT<br><b>VAUGHAN, Dolores</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>585-</b><br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Uremia.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Renal Failure.</b>   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>1 wk.</b><br><b>1 yr.</b> |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>organic heart disease.</b>   |                         |  |  |   |   |
| 19a. DATE OF OPERATION<br><b>none.</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF FOUR, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN LINE 21b; PART 1 OR PART 2)<br>—  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>—                      |  | 21f. LOCATION<br>STREET <b>GREENGROVE</b> COUNTY <b>MD</b> STATE <b>MD</b>  |   |
| 22a. I certify that (s) (this hospital) attended the deceased from <b>Oct 10</b> 19 <b>80</b> , to <b>Oct 14</b> 19 <b>80</b> , that (we) lost<br>saw the deceased alive on <b>Oct 14</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (s) did not view the body after death, so state.) |                         |  |  |   |   |
| 22b. SIGNATURE<br><b>Stephen M. Puentes, M.D.</b>  |                         | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>10/14/80.</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen M. Puentes, M.D.</b>   |                         | 22e. ADDRESS<br><b>Univ. of Md. Hosp. 22 South Greene St., Balt., Md.</b>                        |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>10-17-80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD</b> STATE <b>MD</b>   |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>Oct 20 1980</b>  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Chas. H. Powell F/H</b> ADDRESS <b>319 N. Schroeder St.</b>  |                         | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>  |  |   |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

18061

Very faint, illegible text, possibly a letter or report, spanning the main body of the page. The text is too faded to transcribe accurately but appears to be organized into several paragraphs.



## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 6 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |
|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Raymond Jerome Wimpling</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>11</b> YEAR <b>80</b> HOUR <b>8:00</b> AM           |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH <b>11</b> DAY <b>30</b> YEAR <b>24</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>carpenter</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>                                 |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |  |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1004 Beechfield Ave</b>                                    |
| 14. FATHER'S NAME<br>FIRST <b>Joseph</b> MIDDLE <b>Wimpling</b> LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Alice</b> MIDDLE <b>Tynan</b> LAST   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-16-1075</b>   | 17. INFORMANT<br><b>chant.</b> ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>5303</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Possible Myocardial Infarct.</b>  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>3 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Recurrent Esophageal Stricture, Status post Esophageal Bypass</b>   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>10/2/80</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Recurrent Esophageal Stricture</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/23/80</b> , 19 <b>80</b> , to <b>10/11/80</b> , 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10/11/80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>10/11/80</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph A. Peña M.D.</b>   |  | 22e. ADDRESS<br><b>So Baltimore Gen Hospital</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>burial</b>  | 23b. DATE<br><b>10/14/80</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  | 23d. LOCATION<br>CITY OR TOWN <b>Baltimore City</b> COUNTY <b>Maryland</b> STATE                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ambrose Funeral Home</b> ADDRESS<br><b>13328 Sulphur Spring Rd.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   |   |  |  |  | REG. NO. 80 25970 |  |
|--|--|---|--|--|---|---|--|--|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SARAH WINIK</b>  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10/4/80 OCT 4 1980</b>           |   |  | 2b. HOUR<br><b>12:30 PM</b>  |  |                   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>01 18 1890</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS   |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN.   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                                |  |  |  |                   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Revindele Helms Co. Hosp. &amp; Center</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |                   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3011 ROMARIC CT. ( 21209)</b>  |  |                   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>ABRAHAM YUDOWITZ</b>  |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>EVA LIBBY YUDOWITZ</b> |   |  |  |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-46-3961</b>  |  | 17 INFORMANT ADDRESS<br><b>DAVID WINIK 2A RUSSERN COURT ( 21215)</b>   |   |   |  |  |  |                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CCHF acute and chronic</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.D.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized A.S.D.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>yes</b><br><b>yes</b><br><b>yes</b> |  |   |  |  |   |   |  |  |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |   |  |  |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |  |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> 19 <b>80</b> , to <b>10/4</b> 19 <b>80</b> , that (we) last saw the deceased alive on <b>10/3</b> 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |   |  |  |  |                   |  |
| 22b. SIGNATURE<br><b>Noel D. List</b>  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |   |   |  | 22c. DATE SIGNED<br><b>10/4/80</b>   |  |                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NOEL D. LIST</b>   |  | 22e. ADDRESS<br><b>2434 W. BALDORNE (1215)</b>  |  |  |   |   |  |  |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10/5/80</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMENS CIRCLE</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b>                                |  |  |  |                   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>SOL LEVINSON &amp; BROS</b>   |  |   |  | 601 ADDRESS<br><b>BALTIMORE, MD. (21215)</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>OCT 8 1980</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Ruby Hebrud</b>  |  |                   |  |

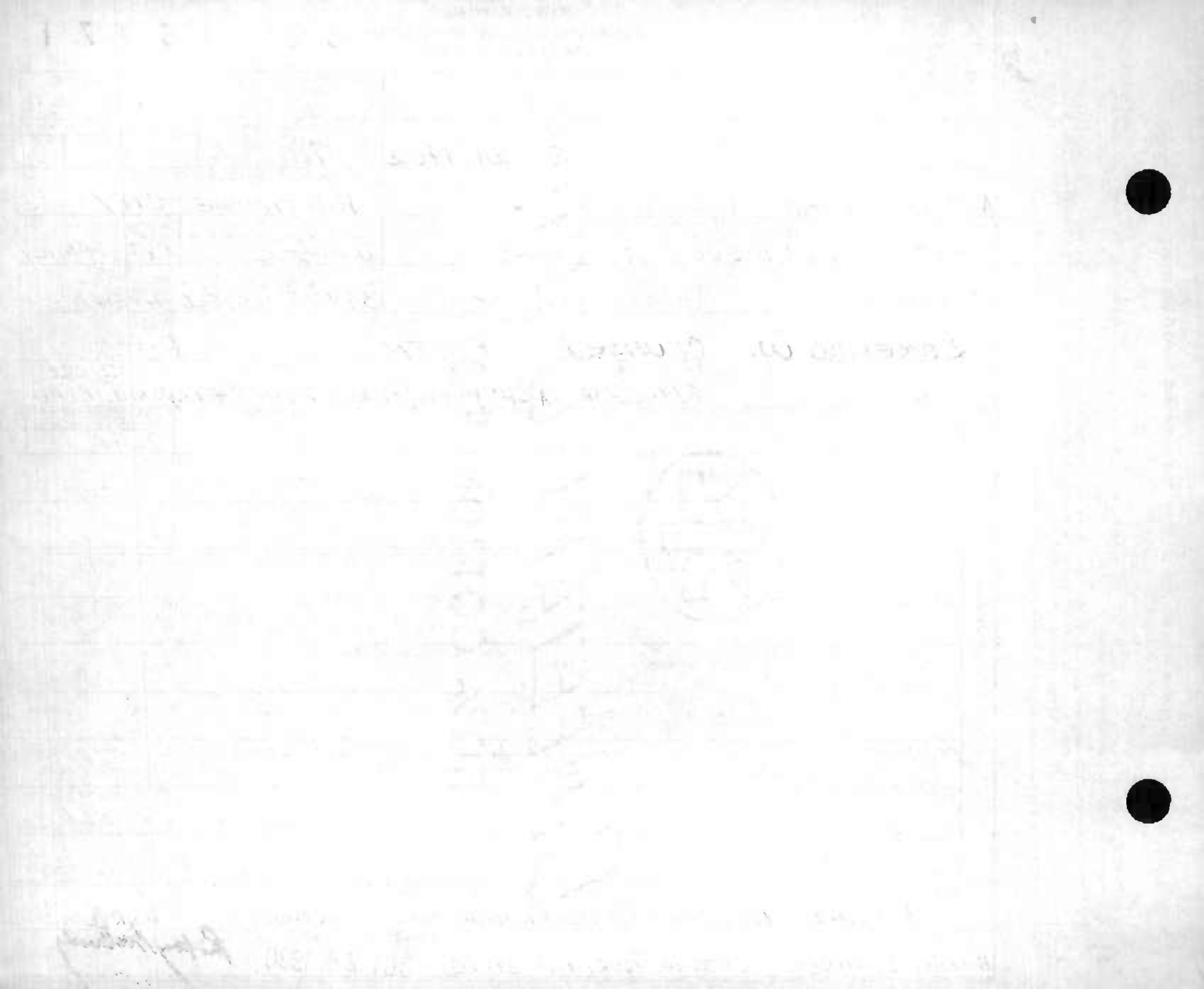
127-44-812

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 0 2 5 9 7 1  |  |  |  |
|--|--|--|--|--|--|--|--|
| FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2b. DATE OF DEATH  |  |  |  |
| Susie Wise   |  |  |  | 10 22 80 2:30 PM   |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Female   |  | Black  |  | 2 24 1902  |  | 78   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Accomack Co. VA.   |  | U. S. A.   |  |  |  | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BALTIMORE  |  | MERCY HOSPITAL   |  | DOMESTIC   |  | PVT. FAMILY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  | 13d. INSIDE CITY LIMITS?   |  |  |  |
| 13a. STATE MARYLAND 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN BALTIMORE  |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| LORENZO W. CHANDLER  |  |  |  | EDITH PITTS  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| NO   |  |  |  | R19-22-3832A   |  | SHERRAN BELL 2916 CHERRYLAND ROAD 21225  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cerebellar hemorrhage  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (b) Arterioelectric heart disease  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| (c) Aortic Aneurysm  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) |  |
|  |  |  |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION  |  |
|  |  |  |  |  |  | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/21/80 to 10/22/80, that (I) (we) lost saw the deceased alive on 10/22/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Mara Sokolow MD  |  |  |  |  |  | 10/22/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| Mara Sokolow   |  |  |  | 301 St. Paul Place Mercy Hospital  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  |
| BURIAL   |  | 10/27/80   |  | BALTO. NATIONAL CEM.   |  | BALTIMORE MARYLAND   |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| HERBERT E. NUTTER 3035 W. NORTH AVENUE   |  |  |  | OCT 28 1980  |  | R. J. H. H. H.   |  |





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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |   |  |   |  |   |   |
|--|--|--|--|---|---|--|---|--|---|---|
| 8 0 2 5 9 7 2  |  |  |  |   |   |  |   |  |   |   |
| 1. FOR STATE REGISTRAR<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |   |  |   |   |
| REG. NO.   |  |  |  |   |   |  |   |  |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GLADYS Ruth WISNER  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 12, 1980   |  |   |  |   | 2b. HOUR<br>7:15 A.M.   |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 3 1920  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>60 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, City MD.                          |   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House Wife       |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |  |   | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>535 Larkfield Road                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George W. Hambree  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha R. Edwards  |  |   |  |   | ADDRESS<br>535 Larkfield Rd.  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>413-26-1388   |  | 17. INFORMANT<br>Elmer F. Wisner  |   |  | Dundalk, Md. 21222  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA<br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CEREBROVASCULAR ACCIDENT<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) ATHEROSCLEROSIS<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)<br>CARCINOMA OF UTERUS |  |  |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>THREE WEEKS<br>TWENTY-NINE DAYS |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |   |   |
| 22a. I certify that (I) this hospital attended the deceased from SEPTEMBER 13, 1980, to OCTOBER 12, 1980, that (I) we lost<br>saw the deceased alive on OCTOBER 12, 1980, and that in (my) opinion death occurred on the date and hour and from the causes stated<br>above. (I) we (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |   |   |
| 22b. SIGNATURE<br>Christina Ynares   |  |  |  |   | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED<br>OCTOBER 12, 1980   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHRISTINA YNARES  |  |  |  |   | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>10/15/1980  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>7922 Wise Ave. Dundalk, Md. 21222  |  |  |  |   | 25. DATE RECD. BY REGISTRAR<br>OCT 14 1980  |  |   |  |   |   |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 7 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |   |  |  |  |
|--|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE J. WOHNER, JR.</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>10</b> YEAR <b>1980</b>    |   |  | 2b. HOUR<br><b>M</b>  |   |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>1</b> YEAR <b>1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                       |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>919 HORNERS LANE</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PHOTOGRAPHER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AIRCRAFT</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>BALTO.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>919 HORNERS LANE</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>GEORGE J.</b> MIDDLE <b>WOHNER</b> LAST <b>SR.</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MARGARET E.</b> MIDDLE <b>ZELLER</b> LAST <b>ZELLER</b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-1396</b>                         |   | 17. INFORMANT<br>NAME <b>George J. Wohner, Jr.</b> ADDRESS <b>423 N. Streeter St.</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>410 -</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>probably 6-12 hrs</b>   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Previous (Recent) Inferior wall myocardial infarction</b>  |  |  |  |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-8</b> 19 <b>80</b> , to <b>10-10</b> 19 <b>80</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-7</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.           |  |  |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>George N. Karkar</b>  |  |  |  |   | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE N. KARKAR, M.D. P.A.</b>  |  |  |  |   | 22e. ADDRESS<br><b>1576 Merritt Blvd. Ste # 9</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>10/13/80</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>OAK LAWN CEM.</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Garth Miller</b> ADDRESS <b>7527 Harford Rd.</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 14 1980</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEMORANDUM FOR THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

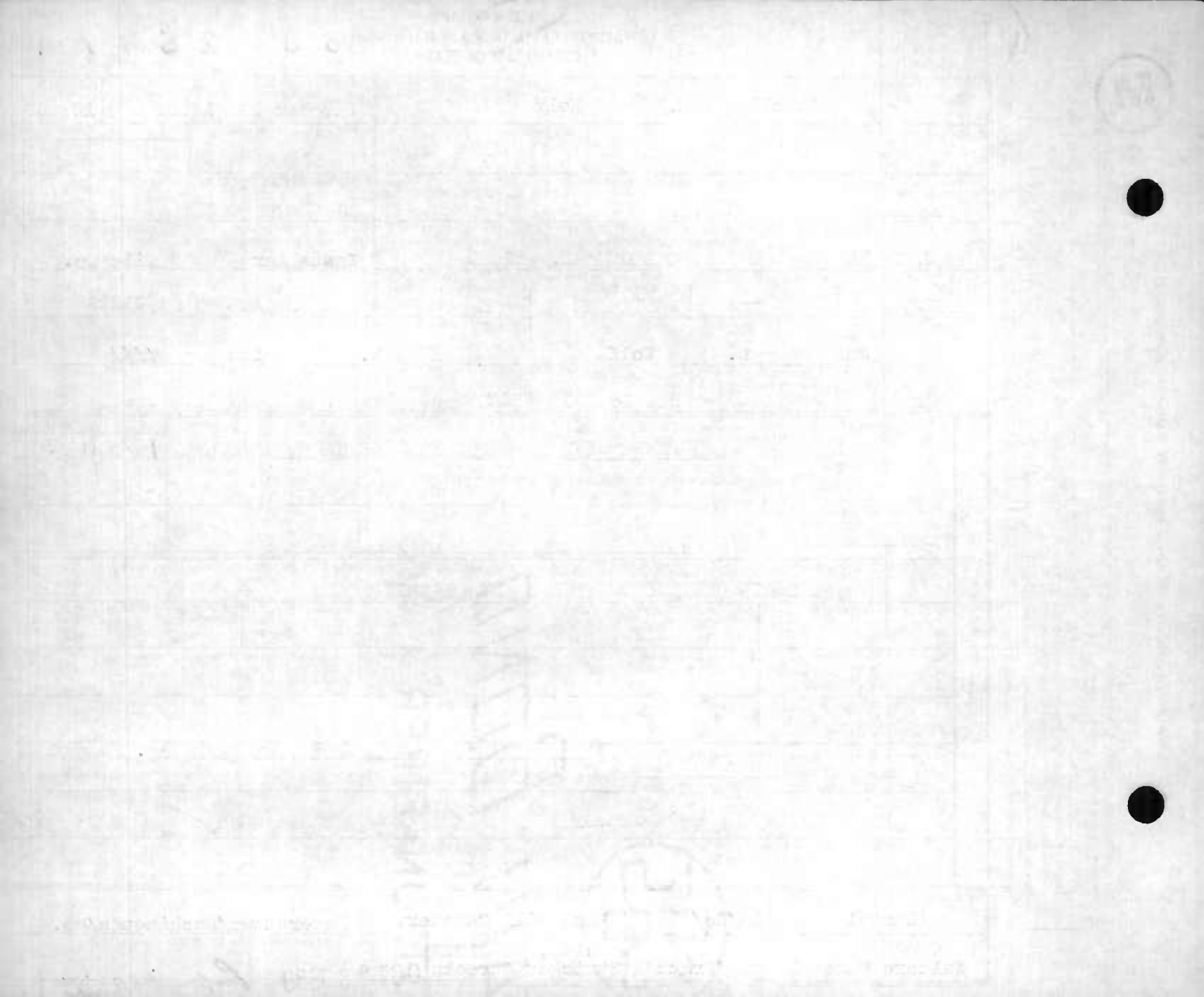
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 80 25974   |  |  |  |  |  |  |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR                                 |  | 2b. HOUR  |  |
| Ardell  |  | M.  |  | Wolf   |  |  |  | October 23 1980  |  | 10:00P <sub>M</sub>                                     |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                   |  | IF UNDER 24 HRS.<br>HOURS MIN.                          |  |
| M   |  | W   |  | 10 1 23  |  | 57 YRS   |  |  |  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |   |  |
| MARYLAND  |  | U.S.A.  |  |  |  | BALTIMORE CITY MD.   |  |  |  |   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| BALTIMORE   |  | 109 S. CALHOUN ST. 21223  |  |  |  |  |  | Installer  |  | Tile Co.  |  |
| 13a STATE   |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?  |  | 13e STREET ADDRESS   |  |   |  |
| MARYLAND  |  | --  |  | BALTIMORE  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 109 S. CALHOUN ST. 21223   |  |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  |  |  |  |   |  |
| Max B. Wolf   |  |   |  | HELEN E. Smith   |  |  |  | WOLF   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS   |  |  |  |   |  |
| YES   |  |   |  | WWII   |  | 216 16 2873 MAX WOLF 109 S. CALHOUN ST. 21223  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>4029<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>17 yrs. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>   |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
|   |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8/12</u> , 19 <u>74</u> to <u>10/6</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10/6</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>  |  |   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10-24-80                                     |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>AMABLE MENDOZA, M.D.   |  |   |  |  |  | 22e. ADDRESS<br>VA MEDICAL CENTER, FORT HOWARD, MD 21052   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| Burial  |  | 10/28/80  |  | Rose Hill Cemetery   |  | Hagerstown/Washington/Md.  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                       |  |   |  |
| Walters Funeral Home/Pratt & Stricker Streets Balto, Md 21223   |  |   |  |  |  | OCT 28 1980  |  |  |  |   |  |

MEDICAL CERTIFICATION

29

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1982



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 7/73  
(VRA 15(4))

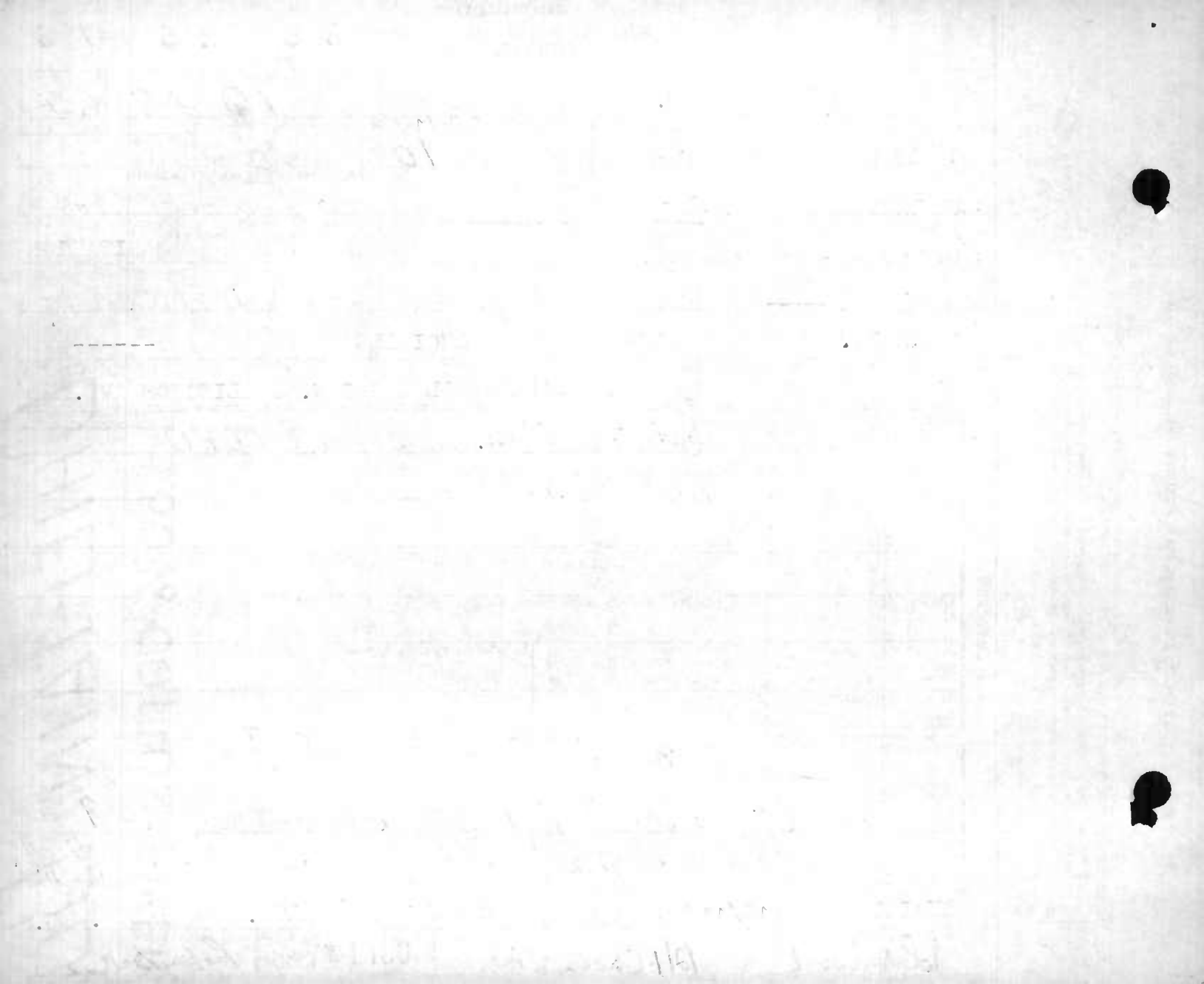
| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |         |  |                                 |  |   |  |                                |   | 80   | 25975 |
|---|--|---------|--|---------------------------------|--|---|--|--------------------------------|---|--|-------|
| 1. FOR STATE REGISTRAR  |  |         | REG. NO.   |                                 |  |   |  |                                |   |  |       |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |         | FIRST MIDDLE LAST  |                                 |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |                                | 2b. HOUR  |  |       |
| Louis F. Wolfe  |  |         |  |                                 |  | 10-9-80   |  |                                | 6:00 AM   |  |       |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH MONTH DAY YEAR |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR MONTHS DAYS |   | 7b. IF UNDER 24 HRS. HOURS MIN.              |       |
| Male  |  | White   |  | 9-4-80                          |  | 70 YRS.   |  |                                |   |  |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                 |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                |   |  |       |
| 35 MARYLAND   |  |         | USA  |                                 |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |                                |   |  |       |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |                                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY   |  |       |
| 30 Baltimore  |  |         | Lincoln  |                                 |  | LABORER   |  |                                | SANITATION  |  |       |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |         | 13b. STATE   |                                 |  | 13c. CITY OR TOWN   |  |                                | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |       |
| 35 MD   |  |         |  |                                 |  | Baltimore   |  |                                | 934 N. Duncan St.   |  |       |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |         | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |                                 |  |   |  |                                |   |  |       |
| 320 HERBERT WOLFE   |  |         | LUCIELLE   |                                 |  |   |  |                                |   |  |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |         | 16b. SOCIAL SECURITY NO.   |                                 |  | 17. INFORMANT ADDRESS   |  |                                |   |  |       |
| 14 NO   |  |         | 217070543  |                                 |  | MARY WOLFE 962 N. COLLINGTON AVE.   |  |                                |   |  |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <u>Bilateral P. Pneumonia &amp; COPD</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>b. <u>Diabetes Mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>c. <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |         |  |                                 |  |   |  |                                |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |         |  |                                 |  |   |  |                                |   |  |       |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |                                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |                                |   |  |       |
|   |  |         | P.M. 19  |                                 |  |   |  |                                |   |  |       |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |                                |   |  |       |
|   |  |         |  |                                 |  |   |  |                                |   |  |       |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-6-1977 to 10-9-80, that (I) (we) lost the deceased above, (I) (we) (did) (did not) view the body after death.  |  |         |  |                                 |  |   |  |                                |   |  |       |
| 22b. SIGNATURE  |  |         | DEGREE   |                                 |  | 22c. DATE SIGNED  |  |                                |   |  |       |
| A. Bayraller MD   |  |         | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                 |  | 10-8-80   |  |                                |   |  |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |         | 22e. ADDRESS   |                                 |  |   |  |                                |   |  |       |
| A. BAYRALER, M.D.   |  |         | 3459 St. Johns Lane, Ellicott City, Md.  |                                 |  |   |  |                                |   |  |       |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         | 23b. DATE  |                                 |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |       |
| BURIAL  |  |         | 10/11/80   |                                 |  | SACRED HEART JESUS  |  |                                | BALTO. BALTO. MD.   |  |       |
| 24. FUNERAL DIRECTOR  |  |         | ADDRESS  |                                 |  | 25a. DATE REC'D. BY REGISTRAR   |  |                                | 25b. REGISTRAR'S SIGNATURE  |  |       |
| J. L. C. C. C.  |  |         | 1211 Chesaco Ave.  |                                 |  | OCT 14 1980   |  |                                | R. J. C. C.   |  |       |

MEDICAL CERTIFICATION

99

1

0703 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

211  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

80 25976

|  |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EMMITT</b>   |  |  | FIRST MIDDLE LAST<br><b>WOODS</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>10 27 80</b>   |  |  | 2b. HOUR<br><b>4:00A<sub>M</sub></b>   |  |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>BLACK</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 22 96</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VETERANS ADMINISTRATION MEDICAL</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BA</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 13e. STREET ADDRESS<br><b>2025 E. Oliver Street</b>  |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HENRY</b> <b>WOODS</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MANDIE</b> <b>BLAND</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW I</b>   |  |  | 17. INFORMANT<br><b>VAMC Clinical Records Balto., Md. 21218</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>dehydration</b><br>2639<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>malnutrition</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 16, 1980</b> to <b>OCTOBER 27, 1980</b> , that (I) (we) lost saw the deceased alive on <b>OCTOBER 27, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>C. Hernandez MD</b>   |  |  |   |  |  | DEGREE<br><b>MD</b>   |  |  | 22c. DATE SIGNED   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. Hernandez MD</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>3900 Loch Raven Blvd. Balto., Md. 21218</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>10/30/80</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Park</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H</b>  |  |  |   |  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1980</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |   |  |  |   |  |  |  |  |  |

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535

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8025977  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
|---|--|---|--|---|--|---|--|--|--|-----------------|--|-----|--|------|--|--|--|------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH           |  | DAY |  | YEAR |  | 2b. HOUR                                     |  |                              |  |  |  |
| George  |  | Wormley   |  | October 16  |  | 1980  |  | 8:51P  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS |  |     |  |      |  |  |  |                              |  |  |  |
| MALE  |  | BLACK   |  | MONTH DAY YEAR<br>8 23 19   |  | 61  |  | MONTHS DAYS  |  | HOURS MIN       |  |     |  |      |  |  |  |                              |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| Virginia  |  | U.S.A.  |  |   |  | Baltimore City  |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| Baltimore   |  | Maryland General Hospital   |  | Selfemployed  |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| Maryland  |  | Baltimore   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 722 Reservoir Street   |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| FIRST MIDDLE LAST<br>George Henry Wormley   |  | FIRST MIDDLE LAST<br>Mary Lena  |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| Yes   |  | 225-16-1837   |  | Ophelia Wormley   |  | 722 Reservoir Street  |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Severe Hypotension and Hypoxia<br>0389<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Adult Respiratory Distress Syndrome<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Possible Sepsis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                              |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Chronic Irreversible Obstructive Lung Disease, history of Tuberculosis   |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
|   |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
|   |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 1, 1980, to October 16, 1980, that <input checked="" type="checkbox"/> (we) lost the deceased alive on October 16, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 22b. SIGNATURE<br>Michael Hull, M.D.  |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  | DEGREE                                       |  | 22c. DATE SIGNED<br>10/17/80 |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  | ADDRESS                                      |  |                              |  |  |  |
| Michael Hull, M.D.  |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  | C/O Maryland General Hospital                |  |                              |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| BURIAL  |  | 10/22/80  |  | Mt Auburn Cemetery  |  | Baltimore Maryland  |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>W.C. Brown Community Fund Home 1206-08 W North Ave  |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>OCT 22 1980  |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |   |  |   |  |  |  |                 |  |     |  |      |  |  |  |                              |  |  |  |

## MEDICAL CERTIFICATION

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**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

BP.

10-11-1944

October 11, 1944

Dear Sir:

My dear Sir:

Enclosed find

Enclosed find

Enclosed find

Enclosed find

Enclosed find

Enclosed find

Enclosed find

Yours

October 11, 1944

October 11, 1944

October 11, 1944

October 11, 1944

October 11, 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH: 16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |   |  |   | 80       | 25978 |
|---|--|---|--|---|---|---|---|--|---|----------|-------|
| 1. FOR STATE REGISTRAR  |  |   |  |   |   |   |   |  |   | REG. NO. |       |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES LETCHER WORTH</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10/09/80</b>  |   |   | 2b. HOUR<br><b>4:45pm</b>  |   |          |       |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/9/08</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |          |       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.                               |   |  |   |          |       |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital Corp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL MFR.</b>   |   |          |       |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>208 ST. HELENA AVE. 21222</b>  |   |          |       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CHARLES L. WORTH, SR.</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>RENA ROGERS</b>   |   |   |  |   |          |       |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217.01.2833</b>   |  | 17. INFORMANT ADDRESS<br><b>MARGARET WORTH (WIFE) SAME AS 13e</b>   |   |   |   |  |   |          |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LUNG CANCER</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b> |          |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |   |   |   |  |   |          |       |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |          |       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |  |   |          |       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |   |          |       |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-6-</b> <b>80</b> , to <b>10-9-</b> <b>80</b> , that (I) (we) lost saw the deceased alive on <b>10-9-</b> <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.                      |  |   |  |   |   |   |   |  |   |          |       |
| 22b. SIGNATURE<br><b>CS Chen</b>  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED   |   |          |       |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. GS. SCHEN</b>   |  |   |  |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY BALTIMORE, MARYLAND 21201</b>  |   |   |  |   |          |       |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10/13/1980</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. CARMEL CEMETERY</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |   |  |   |          |       |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Watts Bros. Riddle</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 17 1980</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Pitney McBrady</b> |  |   |          |       |

MEDICAL CERTIFICATION

29

0000 BP

2025 COPY

2025 COPY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  | 80 25979                                     |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  | REG. NO.                                   |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST                          |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   | 2b. HOUR   |  |  |
| Jean WYMAN   |  |  |  |  |  | 10-12-80  |  |   | 4: PM  |  |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. UNDER 1 YEAR MONTHS DAYS   |  | 7. UNDER 24 HRS. HOURS MIN.                  |  |
| FEMALE   |  | WHITE  |  | 1-18-07  |  | 73 YRS.   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   | MD.  |  |  |
| Russia   |  | USA  |  |  |  | Balt. City  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY HOME  |  |  |  |
| Baltimore  |  | new intake   |  |  |  | HOUSEWIFE   |  | HOME  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b. COUNTY                                |  |  | 13c. CITY OR TOWN   |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| MARYLAND   |  |  |  |  |  | BALTIMORE   |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |  |  |   |  |   |  |  |  |
| KOS WARSHAVSKY   |  |  | MARIAM KRAMER                              |  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |  |  |
| NO   |  | 0-99-05-6077   |  | IRVING G. WYMAN  |  | 6201 NORVO RD. (21207)  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) - Acute Myocardial infarction   |  |  |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) - Arteriosclerotic Heart disease   |  |  |  |  |  |   |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |   |  |  |  |
| Parkinson's disease, Hypothyroidism  |  |  |  |  |  |   |  |   |  |  |  |
| 19. DATE OF OPERATION  |  | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
|  |  |  |  |  |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 7b; PART I OR PART 2)   |  |   |  |   |  |  |  |
|  |  |  |  |  |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
|  |  |  |  |  |  |   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from 9/29/1976 to 10/12/1980, that (we) last saw the deceased alive on 3:45pm 10/12/1980, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE Mary Jones  |  |  |  | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED 10/12/80   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KHINI M. TUN   |  |  |  | 22e. ADDRESS 2110 Pot Spring Road Balto Md 21093   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| REMOVAL  |  | 10/14/80   |  | WELLWOOD CEMETERY  |  | FARMINGDALE, N.Y.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS  |  |  |  | 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  | 25a. DATE REC'D. BY REGISTRAR OCT 14 1980   |  | 25b. REGISTRAR'S SIGNATURE [Signature]  |  |  |  |

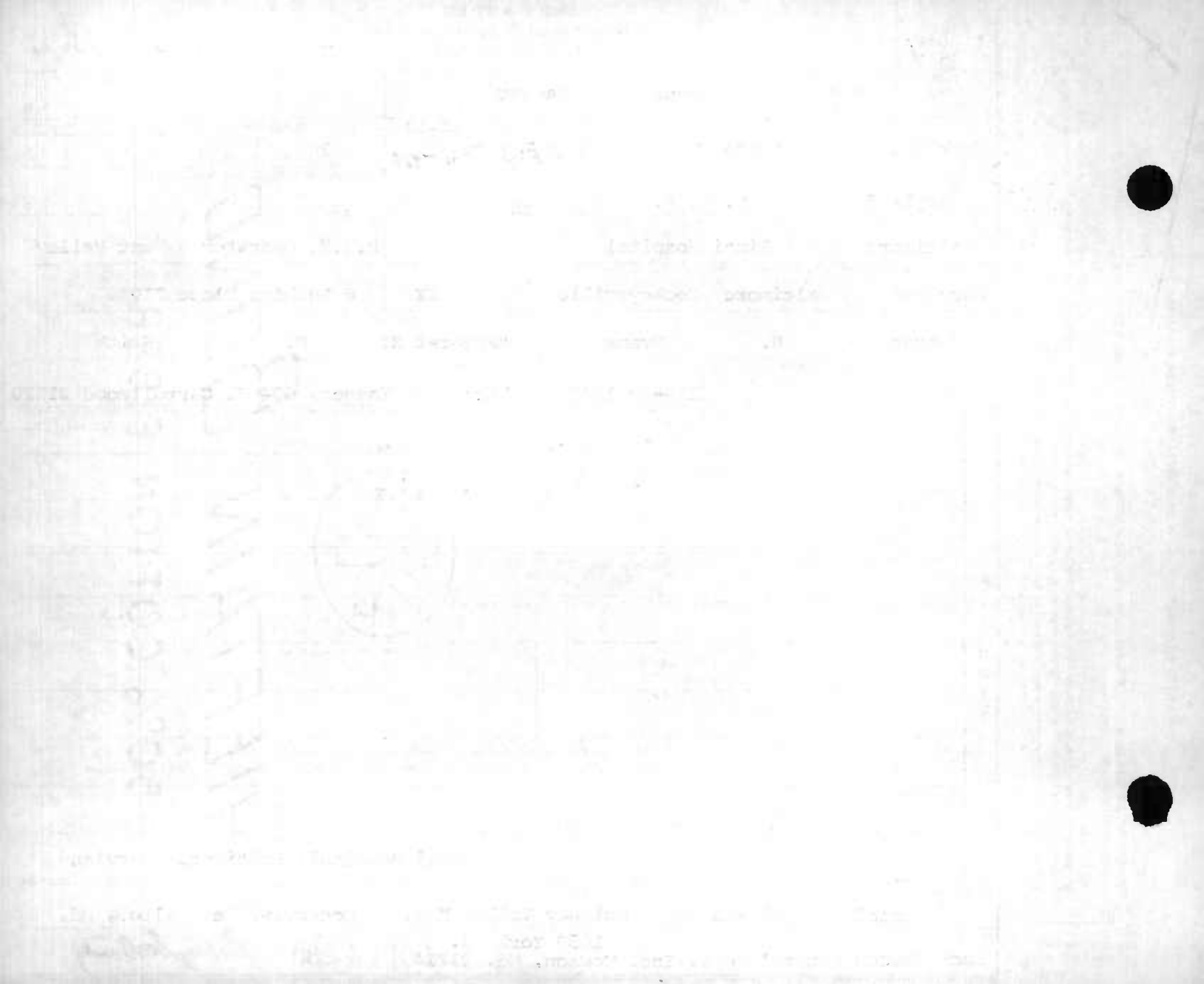


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  | 8025980  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MARY   |  | MIDDLE AGNES   |  | LAST YAEGER   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR HOUR  |  |
|   |  |  |  |  |  |   |  | 10 10 80   |  | 7:15 A M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |
| Female F  |  | White C  |  | 2821-XXXX-XXXX FEB. 21 1910  |  | 70 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| Maryland  |  | U. S. A.   |  |  |  | Baltimore city MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |   |  |  |  |  |  |
| Baltimore   |  | Sinai Hospital   |  |  |  |   |  |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |  |  |  |  |
| P.B.X. Operator   |  | Hunt Valley  |  |  |  |   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |   |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |  |  |
| Maryland  |  | Baltimore  |  | Cockeysville   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 6 Beehive Place 21030  |  |  |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |  |  |
| FIRST MIDDLE LAST George H. Evans   |  |  |  | FIRST MIDDLE LAST Margaret M. Smith  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT ADDRESS  |  |  |  |
| NO  |  |  |  | 215-40-1949  |  |   |  | Charles W. Yaeger, 604 F. Carrollwood 21220                                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u>  |  |  |  |  |  |   |  |  |  |  |  |
| 1539 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>metastatic Ca colon</u>   |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |  |  |
|   |  |  |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-15-80</u> , 19 <u>80</u> , to <u>10-10</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>10-10</u> <u>6 AM</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE <u>Mark B. Burson</u>  |  |  |  | DEGREE <u>MD</u>   |  |   |  | 22c. DATE SIGNED <u>10-10-80</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |  |  |  |  |
|   |  |  |  | Sinai Hospital, Baltimore, Maryland  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| Burial  |  | 10-13-80   |  | Dulaney Valley Mem.  |  |   |  | Cockeysville, Balto., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  | 25a. DATE REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |  |  |  | 1050 York Rd. OCT 14 1980  |  | <u>Lesley A. Burson</u>   |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 25981

1- FOR  
STATE  
REGISTRAR

|  |                         |  |   |  |  |  |  |   |  |
|--|-------------------------|--|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Billy Young</b>   |                         |  |   | 2a. DATE KNOWN OF DEATH <b>XX</b> MONTH <b>10</b> DAY <b>28</b> YEAR <b>80</b>   |  |  |  | 2b. HOUR <b>10:40</b>                                   |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>5</b> YEAR <b>55</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>25</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>25</b> DAYS <b>25</b> HOURS <b>25</b> MIN.   | IF UNDER 24 HRS.<br>HOURS <b>25</b> MIN. | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>10</b> DAY <b>28</b> YEAR <b>80</b>                 |  | 10:40 P M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                            |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 13e. STREET ADDRESS<br><b>425 N. Patterson Pk. Ave.</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Robert</b> MIDDLE <b>Williams</b> LAST <b>Williams</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Elizabeth</b> MIDDLE <b>Young</b> LAST <b>Young</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |   | 17. INFORMANT<br><b>Elizabeth Ypong</b>  |  | ADDRESS<br><b>425 N. Patterson Pk. Ave.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b><br>9654<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |                         |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9:38 P. 10 28 80</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot in head walking down street</b>                         |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Street</b>   |   | 21f. LOCATION<br>STREET <b>500 Blk. N. Payson St., Baltimore,</b> CITY OR TOWN <b>Baltimore,</b> COUNTY <b>Md.</b> STATE <b>Md.</b>                      |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan M.D.</b>   |                         |  |   | TITLE (SPECIFY)<br><b>Assistant</b>  |  | MEDICAL EXAMINER   |  | DATE SIGNED <b>10/29/80</b>                             |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>  |                         | ADDRESS <b>111 Penn Street</b>   |   |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>11/3/80</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville, Md.</b> COUNTY <b>MD.</b> STATE <b>MD.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

0603



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER. TO EXECUTE THE CERTIFICATE, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO THE CORONER, GIVE PAGE 4. TO THE DISTRICT ATTORNEY, GIVE PAGE 5. TO THE COUNTY CLERK, GIVE PAGE 6. TO THE JUDGE OF THE PROBATE COURT, GIVE PAGE 7. TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR RECORDS. TO THE DISTRICT ATTORNEY, GIVE PAGE 6. TO THE COUNTY CLERK, GIVE PAGE 7. TO THE JUDGE OF THE PROBATE COURT, GIVE PAGE 8.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 101 WEST BALTIMORE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 25982

|  |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
|--|--|--|--|---|--|------------------------------------|--|--|--|---|--|---|--|--|--|-------------------|--|---|--|---------------------------|--|
| FOR<br>1- STATE<br>REGISTRAR   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |   |  |                                    |  |  |  |   |  | REG. NO. 25982  |  |  |  |                   |  |   |  |                           |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  |   |  | FIRST MIDDLE LAST                  |  | 2a. DATE KNOWN<br>OF DEATH   |  |   |  | 2b. HOUR  |  |  |  |                   |  |   |  |                           |  |
| Mary Young   |  |  |  |   |  |                                    |  | ESTIMATED MONTH DAY YEAR 10 17 80  |  |   |  | M   |  |  |  |                   |  |   |  |                           |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                  |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.                        |  | 2c. DATE<br>PRONOUNCED<br>DEAD                                      |  | 2d. HOUR                                     |  |                   |  |   |  |                           |  |
| Female   |  | Black  |  | MONTH DAY YEAR 2 11 1898                                    |  | LAST BIRTHDAY 82 YRS.              |  | MONTHS DAYS HOURS MIN.   |  |   |  | MONTH DAY YEAR 10 18 80   |  | 2:23 M                                       |  |                   |  |   |  |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                                |  |                                    |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                   |  |   |  |                           |  |
| MARYLAND   |  |  |  | US  |  |                                    |  |  |  |   |  | Baltimore City MD.  |  |  |  |                   |  |   |  |                           |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  |                                    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                   |  |   |  |                           |  |
| Baltimore  |  |  |  | 2511 WEST LAFAYETTE AVE.                                    |  |                                    |  | DOMESTIC   |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| 13a. STATE   |  |  |  |   |  |                                    |  |  |  |   |  |   |  | 13b. COUNTY                                  |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS       |  |
| MARYLAND   |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  | BALTIMORE         |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 3330 GWYNNS FALLS PARKWAY |  |
| 14. FATHER'S NAME  |  |  |  |   |  | FIRST MIDDLE LAST                  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  | FIRST MIDDLE LAST                            |  |                   |  |   |  |                           |  |
| CORNELIUS  |  |  |  |   |  | YOUNG                              |  | EMMA BARNES  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  |  |  |   |  | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT  |  |   |  |   |  | ADDRESS                                      |  |                   |  |   |  |                           |  |
| (YES, NO, OR UNKNOWN)  |  |  |  |   |  |                                    |  | RAYMOND YOUNG  |  |   |  |   |  | 2511 WEST LAFAYETTE AVE.                     |  |                   |  |   |  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |                                    |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                   |  |   |  |                           |  |
| PART I DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease  |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| IMMEDIATE CAUSE (a): 4292  |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| (b):   |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| (c):   |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                    |  |  |  |   |  | 20. AUTOPSY?  |  |  |  |                   |  |   |  |                           |  |
|  |  |  |  |   |  |                                    |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                   |  |   |  |                           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |  |                                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
|  |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
|  |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |                                    |  |  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| ACTUAL SIGNATURE   |  |  |  | M.D.  |  |                                    |  | TITLE (SPECIFY) Assistant  |  |   |  | DATE SIGNED 10-20-80  |  |  |  |                   |  |   |  |                           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |  |  | Margarita A. Korell, M.D.                                   |  |                                    |  | ADDRESS 111 Penn Street  |  |   |  |   |  |  |  |                   |  |   |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE (SPECIFY)   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |   |  |  |  |                   |  |   |  |                           |  |
| BURIAL   |  |  |  | 10-22-80  |  | NEW CATHEDRAL                      |  |  |  | BALTIMORE MARYLAND                      |  |   |  |  |  |                   |  |   |  |                           |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | ADDRESS   |  |                                    |  | 25. DATE RECEIVED BY REGISTRAR   |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                   |  |   |  |                           |  |
| ELIZABETH L. PHILLIPS  |  |  |  | 1721-27 N. MONROE ST.                                       |  |                                    |  | OCT 27 1980  |  |   |  | [Signature]   |  |  |  |                   |  |   |  |                           |  |

1-1-80

1980

1-1-80

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified *advance*.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |   |  |
|--|--|--|--|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MARY MIDDLE Ellen LAST Young   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>10 17 80                                   |   | 2b. HOUR<br>11:06 AM   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 7 98   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.                                |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New Jersey  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hosp. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Health Ctr.   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Balto.  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>301 McMechen St.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                                     |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Unkn.   |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>218-32-3329A |   | 17. INFORMANT ADDRESS  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr.   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                     |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19              |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/17/80, 19 80, to 10/17, 19 80, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br>Charity C. Fox MD  |  |  |  |   | DEGREE<br>MD   |   | 22c. DATE SIGNED<br>10/17/80   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARITY C. FOX MD   |  |  |  |   | 22e. ADDRESS<br>UNIVERSITY HOSPITAL  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal   |  |  | 23b. DATE<br>10/17/80  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Anatomy Board   |  |  |  |   | ADDRESS<br>Balto., Md.   |   | 25a. DATE RECD. BY REGISTRAR<br>OCT 27 1980  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

New Jersey  
 Police  
 301 Montross St.  
 Newark  
 Police City  
 Police City

OCT 23 1960

Police

Police

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 0 2 5 9 8 4  
REG. NO.1 - FOR  
STATE  
REGISTRAR

|  |  |   |   |  |  |  |  |  |   |  |  |  |  |
|--|--|---|---|--|--|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Sadie V. Young   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10/19/80 |  |  | 2b. HOUR<br>11:40 P M  |  |  |   |  |  |  |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>BLACK   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 22 1884   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>96 YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN   |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                |  |  |   |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MAID |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOSPITAL |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |   |   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTIMORE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>2438 WOODBROOK AVE. |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>HENRY BROOKS  |  |   |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JOSEPHINE HAMMOND        |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |   | 16b. SOCIAL SECURITY NO.<br>216-54-2905  |  | 17 INFORMANT<br>ADDRESS<br>ELIZABETH ELSEY 2045 RUXTON AVE               |  |  |   |  |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma of Colon with<br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) distant metastases<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/16, 1980, to 10/19, 1980, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br>Moses Gebremariam  |  |   |   |  |  |  |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>10/19/80               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Moses Gebremariam   |  |   |   |  |  |  |  | 22e. ADDRESS   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   |   | 23b. DATE<br>OCTOBER 24 1980   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARBUTUS MEM. PK                    |  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE COUNTY MD.   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>HERBERT E. NUTTER 3035 W. NORTH AVE   |  |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1980                             |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |  |  |  |  |

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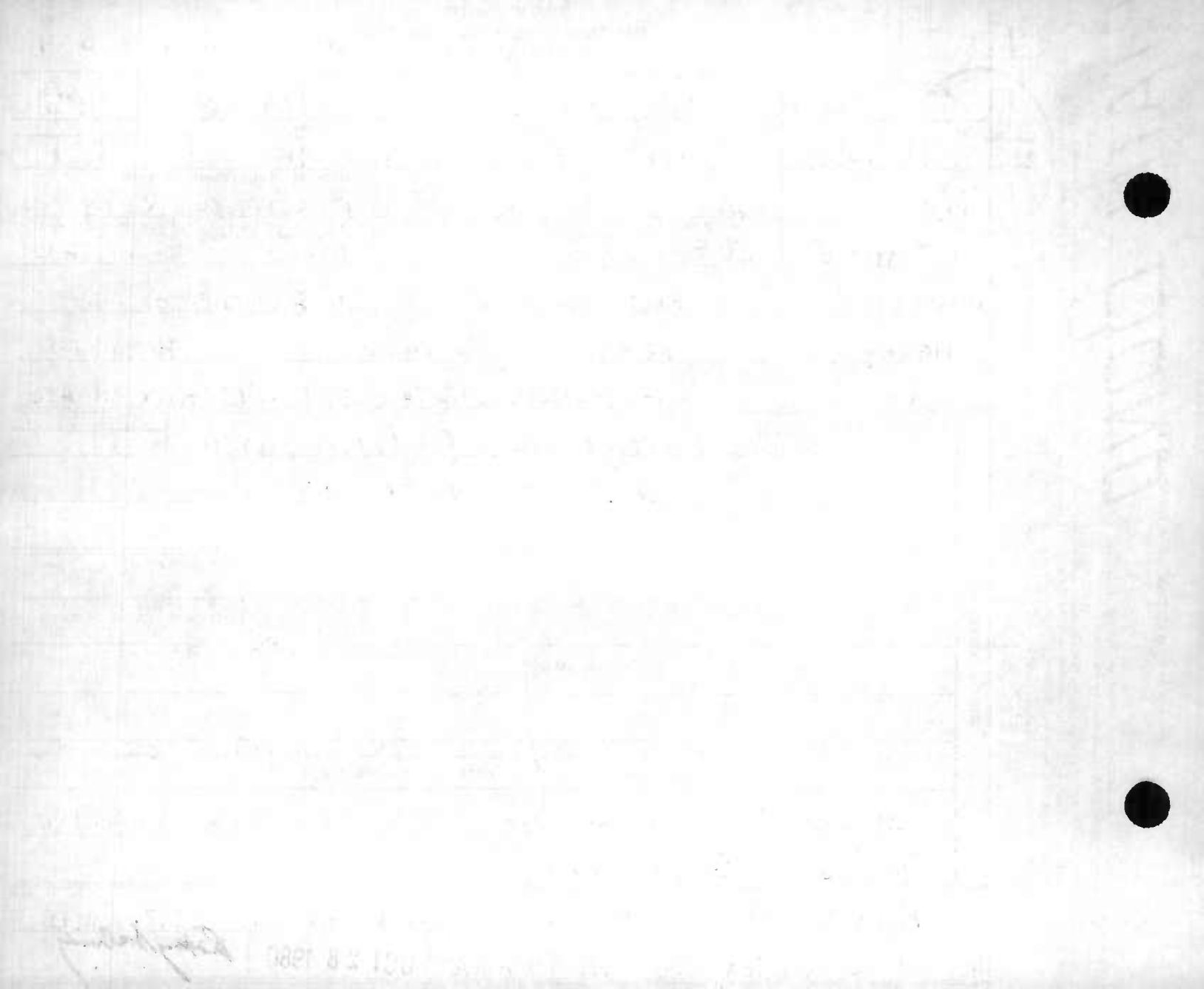
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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

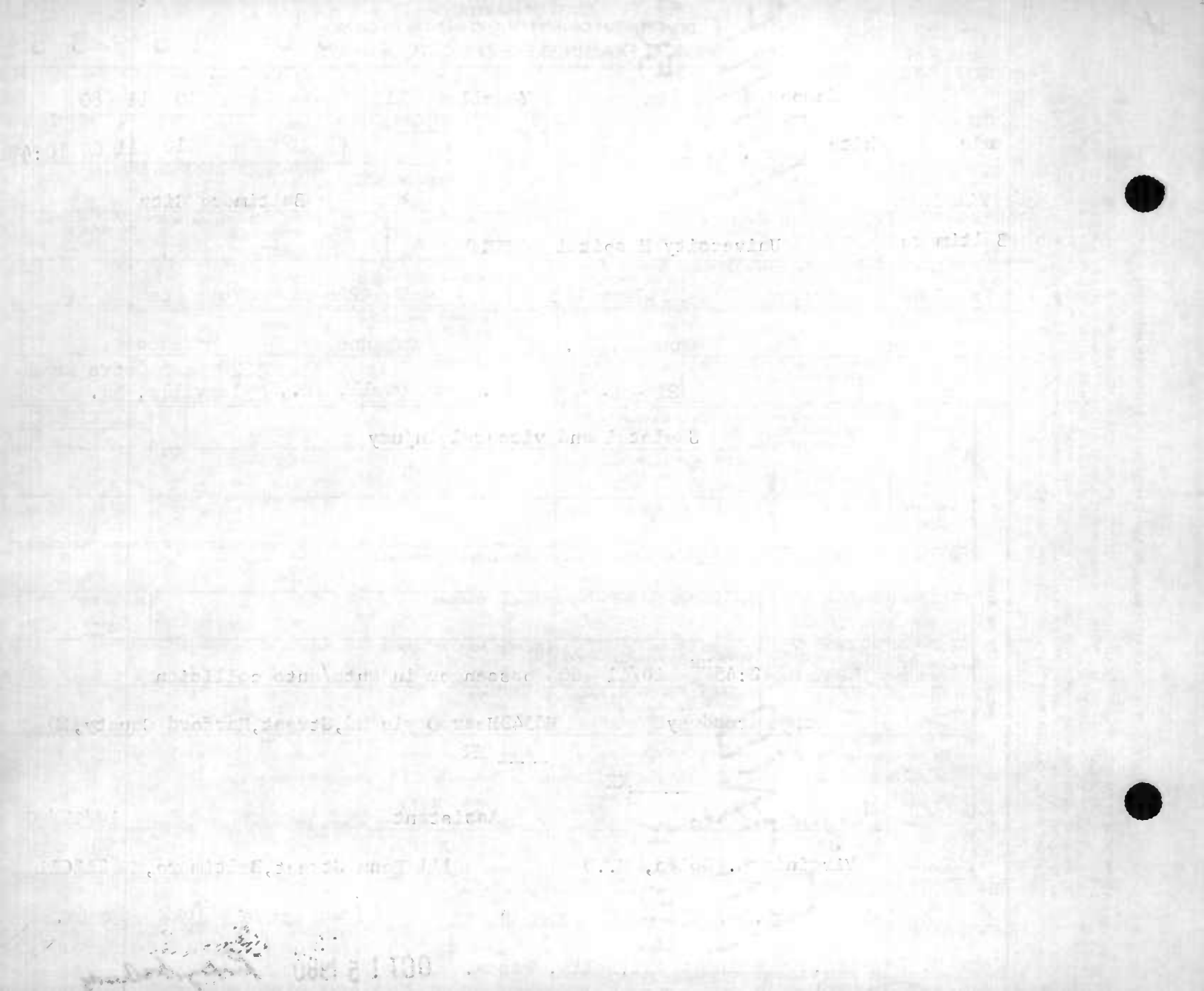


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |   |  |   |  |   |  |   |  | REG. NO. 25985  |                |
|--|---------|---|--|---|--|---|--|---|--|---|----------------|
| 1. FOR STATE REGISTRAR   |         |   |  |   |  |   |  |   |  |   |                |
| 1. DECEASED NAME (TYPE OR PRINT)   |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH                                       |  | xx  | MONTH DAY YEAR |
| Kemper   |         | Rea   |  | Yowell  |  | III   |  | 10  |  | 11  | 1980           |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD  |                |
| male   | white   | Aug. 6, 1963  |  | 17 YRS  |  |   |  |   |  | 10 11, 1980   |                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  | 2d. HOUR  |                |
| Virginia   |         | USA   |  | WIDOWED   |  | DIVORCED  |  | Baltimore City  |  | 10:40 PM  |                |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                |
| Baltimore  |         | University Hospital (MIEM)  |  |   |  |   |  | Student   |  |   |                |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |   |                |
| Maryland   |         | Harford   |  | Pylesville  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 5226 Fawn Grove Road  |  |   |                |
| 14. FATHER'S NAME  |         |   |  | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |   |  |   |                |
| FIRST MIDDLE LAST  |         |   |  | FIRST MIDDLE LAST   |  |   |  |   |  |   |                |
| Kemper Rea Yowell, Jr.   |         |   |  | Suzanne Markwood  |  |   |  |   |  |   |                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         |   |  | 16b. SOCIAL SECURITY NO.                                    |  |   |  | 17. INFORMANT   |  |   |                |
| No   |         |   |  | 216-82-6436   |  |   |  | K. Rea Yowell, Jr., Pylesville, Md.                           |  |   |                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |                |
| PART 1 DEATH WAS CAUSED BY:  |         |   |  |   |  |   |  |   |  |   |                |
| IMMEDIATE CAUSE (a) Skeletal and visceral injury   |         |   |  |   |  |   |  |   |  |   |                |
| 8121   |         |   |  |   |  |   |  |   |  |   |                |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |   |  |   |                |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |         |   |  |   |  |   |  |   |  |   |                |
| (b)  |         |   |  |   |  |   |  |   |  |   |                |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |  |   |  |   |  |   |  |   |                |
| (c)  |         |   |  |   |  |   |  |   |  |   |                |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |   |  |   |  |   |  |   |                |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |  | 20. AUTOPSY?  |                |
|  |         |   |  |   |  |   |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |   |                |
|  |         |   |  | HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR     |  | passenger in auto/auto collision  |  |   |  |   |                |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |  |   |  |   |                |
|  |         |   |  | roadway   |  | Md543 Near Doyle Rd, Street, Harford County, MD                               |  |   |  |   |                |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |   |  |   |  |   |  |   |                |
| ACTUAL SIGNATURE   |         |   |  | TITLE (SPECIFY)   |  |   |  | DATE SIGNED   |  |   |                |
| Virginia L. Dolan  |         |   |  | Assistant   |  |   |  | 10/12/80  |  |   |                |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |  | ADDRESS   |  |   |  |   |  |   |                |
| Virginia L. Dolan, M.D.  |         |   |  | 111 Penn Street, Baltimore, MD 21201                        |  |   |  |   |  |   |                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                          |  | 23d. LOCATION   |  | COUNTY  |  | STATE   |                |
| Burial   |         | Oct. 14, 1980   |  | Fawn Grove UM   |  | Fawn Grove  |  | York  |  | Penna.  |                |
| 24. FUNERAL DIRECTOR   |         |   |  | 25a. DATE REC'D. BY REGISTRAR                               |  |   |  | 25b. REGISTRAR'S SIGNATURE                                    |  |   |                |
| NAME ADDRESS   |         |   |  | OCT 15 1980   |  |   |  | [Signature]   |  |   |                |
| John H. Harkins, 600 Main Street, Delta, Penna.  |         |   |  |   |  |   |  |   |  |   |                |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 0 2 5 9 8 6<br>REG. NO.  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>SAPAK   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>10 25 80  |  |  |  |
| 3 SEX<br>FEMALE   |  |  |  | 7b. HOUR<br>6:55 PM  |  |  |  |
| 4 RACE<br>WHITE   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>07 13 1904  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 YRS.  |  | 7a. MONTH DAY YEAR<br>10 25 80   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>RUMANIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>YES U.S.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.   |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LEVINDALE |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. STATE<br>MD.   |  |  |  | 13b. CITY OR TOWN<br>RANDALLSTOWN  |  | 13c. STREET ADDRESS<br>3941 NEMO RD. RANDALLSTOWN, MD  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>PHILIP RAPPAPORT   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DINAH UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO<br>118-24-2590   |  |  |  |
| 17 INFORMANT<br>MYRON ZAIDMAN 32 REGENT CIRCLE  |  |  |  | ADDRESS<br>STATEN ISLAND N.Y. (10312)  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Multiple Syst. Failure<br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) ASD<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Approximate Interval Between Onset and Death<br>Weeks<br>years- |  |  |  |  |  | 19   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 06/22, 19 78, to 10/25, 19 80, that (I) (we) last saw the deceased alive on 10/25, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.      |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>M.D.  |  |  |  | DEGREE<br>M.D.   |  | 22c. DATE SIGNED<br>10/25/80   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M.D. LIST  |  |  |  | 22e. ADDRESS<br>Greenway & Belvidere Dr. N.Y.  |  |  |  |
| 23a. BURIAL, CREMATION OR REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>10/27/80  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FLORAL PARK CEM  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>DEANS, NEW JERSEY  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>SOL LEVINSON & BROS BALTIMORE, MD. 21215   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 28 1980   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |  | 80  | 25 | 98 | 7 |
|---|--|---|--|---|--|---|--|--|--|---|----|----|---|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  | REG. NO.  |    |    |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>John J. Zalenski   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>October 22, 1980   |  | 2b. HOUR<br>9 <sup>00</sup> A <sup>M</sup>   |  |   |    |    |   |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 10 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |   |    |    |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |   |    |    |   |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3046 Mayfield Ave. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Longshoreman                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Union   |  |   |    |    |   |
| 13a. STATE<br>Md.   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3046 Mayfield Ave.  |  |   |    |    |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ignatius Zalenski   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen  |  |   |  |  |  |   |    |    |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-07-5328  |  | 17. INFORMANT<br>Catherine Zalenski (wife)  |  | ADDRESS<br>same address   |  |  |  |   |    |    |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>5 YRS.<br>WITH ATRIAL FIBRILLATION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>METASTATIC CARCINOMA OF PROSTATE</u> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>18 MOS. |    |    |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |    |    |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |    |    |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |    |    |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>APRIL 5</u> , 19 <u>60</u> , to <u>10-22</u> , 19 <u>80</u> , that (I) (we) lost<br>saw the deceased alive on <u>10-13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  | 22c. DATE SIGNED<br>10-23-80                            |    |    |   |
| 22b. SIGNATURE<br><u>Carlton L. Sexton, M.D.</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  |  |  |   |    |    |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Carlton L. Sexton  |  |   |  | 22e. ADDRESS<br>819 Park Ave.   |  |   |  |  |  |   |    |    |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>10/25/80   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.  |  |  |  |   |    |    |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>S. Imunek Funeral Home, Inc.  |  |   |  | ADDRESS<br>3331 Brehms Lane<br>Balto. Md. 21213   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 24 1980  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Patricia A. Bundy</u>   |  |   |    |    |   |

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum format with various fields and lines of text.]

CONFIDENTIAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 5 9 8 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |   |  |
|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JOHN ZEBACK</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>October 24, 1980</b>  |   | 2b. HOUR<br><b>8P</b> M  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>July 14, 1928</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.                                       | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penna.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3316 Ellerslie Ave.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>-</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>                              | 13e. STREET ADDRESS<br><b>3316 Ellerslie Ave.</b>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Peter Zeback</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Violet Matilda</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes Unknown</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>212-26-2222</b>  | 17. INFORMANT ADDRESS<br><b>Jean Zeback, sister, 1506 Aldeney Ave. 21220</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>5715</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>End stage Cirrhotic Liver Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTE BY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 6</b> , 19 <b>80</b> , to <b>Oct 24</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Sept 6</b> , 19 <b>80</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Dr. L. J. P. M. D.</b>  |   | DEGREE  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>10-27-80</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. LAMPHER</b>  |   | 22e. ADDRESS<br><b>Baltimore City Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>10/28/80</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                     |  |
| 24. FUNERAL DIRECTOR<br><b>Schamunek Funeral Home, Inc.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>OCT 28 1980</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert K. ...</b>                                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  | REG. NO. 25989   |  |
|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR  |   |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Anna S. Zielinski</i>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Oct. 19, 1980</i>                                     |  | 2b. HOUR<br>M  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Sept. 14, 1914</i>  |  | 6. AGE (IN YEARS LAST DAY) MONTHS DAYS HOURS MIN.<br><i>66</i>                 |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY & COUNTY OF DEATH<br><i>Baltimore City</i> MD.               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Balto. Gen. Hospital</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Bottler</i>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Distillery</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><i>Maryland</i>   | 13b. COUNTY<br><i>A.A.O.</i>  | 13c. CITY OR TOWN<br><i>Linthicum</i>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><i>911 Wanda Rd. Linthicum, Md.</i>                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Jaceim ----- Semeniuk</i>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Mary ----- Stankiewicz</i>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |   | 16b. SOCIAL SECURITY NO.<br><i>214-05-3864</i>  |  | 17. INFORMANT ADDRESS<br><i>Mr. John N. Zeilinski, Same as above</i>           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>410 -</i><br>DUE TO, OR AS A CONSEQUENCE OF <i>coronary thrombosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |   |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>Jan 1970</i> to <i>Oct 2, 1980</i> , that (I) (we) last saw the deceased alive on <i>10-2</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |   |   |  |  |  |
| 22b. SIGNATURE<br><i>E. Schutzer</i>  |   | DEGREE  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>EUGENE SCHNITZER, MD</i>  |   | 22e. ADDRESS<br><i>3904 S. Hammer St. Balt. Md.</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |   | 23b. DATE<br><i>Oct. 22, 1980</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Cross Cemetery</i>               |  |
| 23d. LOCATION CITY OR TOWN<br><i>Baltimore</i>  |   | COUNTY<br><i>Maryland</i>   |  | STATE  |  |
| 24. FUNERAL DIRECTOR NAME<br><i>McCutty Funeral Home, 4200 Pennington Ave. Balto.</i>   |   | ADDRESS<br><i>Md. 21226</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>OCT 22 1980</i>                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>L. J. [Signature]</i>  |   |   |  |  |  |

